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Foreword

In Bangladesh, about 35 million people representing almost 25 percent of the population live in urban areas, a large proportion of them are slum dwellers. Slum dwellers have less knowledge about and access to essential basic health services. Urban Primary Health Care Project, a Public-Private Partnership, is an innovative initiative with the goal to improve the health status of the urban population, specially the poor.

In order to have greater impact of the health service delivery activities of the project, the Behavior Change Communication and Marketing (BCCM) component of UPHCP-II was given due importance which focused on raising awareness among the urban population, particularly the poor.

For implementing BCCM activities, Bangladesh Center for Communication Programs (BCCP) was selected as the BCCM firm of UPHCP-II. It was felt important to assess the impact of all the BCCM activities which could contribute designing of more effective health service delivery program in urban areas. In view of this, BCCP earlier coordinated conduction of a Knowledge, Attitude, Behavior and Practice (KABP) survey in 2008 which generated baseline data with regard to a set of BCCM indicators. At the last stage of the project, BCCP coordinated conduction of an End-line Evaluation by an independent research agency (Org-Quest Research Limited) in 2011 to generate data against the same set of indicators as those of KABP survey.

The successful completion of the End-line Evaluation of BCCM activities was made possible by the contributions of a number of organizations and individuals. I would like to thank PIUs and the PA NGOs for their active support and participation in the End-line Evaluation, BCCP for coordinating and Org-Quest Research Limited for conducting the evaluation.

June 10, 2012

Md. Abu Bakr Siddique
Project Director
UPHCP-II

Acknowledgement

The purpose of the Second Urban Primary Health Care Project (UPHCP-II) is to improve the health status of the urban population, especially the poor, through improved access to and utilization of efficient, effective and sustainable Primary Health Care (PHC) services. To make the health service delivery of the project more effective, the Behavior Change Communication and Marketing (BCCM) component of UPHCP-II was considered an important element. Considering importance of BCCM activities for the overall success of the program, Bangladesh Center for Communication Programs (BCCP) was selected as the BCCM firm of UPHCP-II.

An important thrust of the BCCM strategy was to generate baseline data with regard to selected BCCM indicators at the beginning and then collect data against the same indicators at the end of the project period and compare those to find the impact of the BCCM interventions in enhancing overall coverage of the program. Therefore, a Knowledge, Attitude, Behavior and Practice (KABP) survey was conducted in 2008 and an End-line Evaluation was conducted in 2011. Both the studies were conducted by an independent research organization named OrgQuest Research Limited. The results of the end-line evaluation have been nicely presented in this report and we believe the information would be useful to all concerned.

We recall with gratitude the appropriate guidance and tremendous help, support and cooperation that we received from Mr. Md. Abu Bakr Siddique, the Project Director, UPHCP-II. We extend our sincere thanks to him. We also thank Dr. Sharmin Mizan, Deputy Project Director (Technical) and Mrs. Farzana Akter, BCC and Research Officer, UPHCP-II for their sincere cooperation, support and help in every stage of both the studies. We express our gratitude to the officials of the participating PIUs and the PA NGOs for extending their help and support. We are very much indebted to the respondents of the studied for giving their valuable time. Sincere thanks to Org-Quest Research Limited for conducting both the studies and for preparing the reports with quality and on time. Thanks also to the concerned officials of BCCP who were involved in coordinating the studies. Finally, we extend our whole-hearted thanks to the reviewers of the End-line Evaluation report for giving their time and valuable comments.

June 10, 2012

Mohammad Shahjahan
Director & CEO
BCCP

List of Acronyms

ANC	Ante Natal Care
ARI	Acute Respiratory Infection
BCCM	Behavior Change Communication and Marketing
BCC	Behavior Change Communication
CCs	City Corporations
CRHCC	Comprehensive Reproductive Health Care Center
DOTS	Direct Observation Treatment System
ECP	Emergency Contraceptive Pill
EOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
ESP	Essential Service Package
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
KABP	Knowledge Attitude Behavior Practice
MR	Menstruation Regulation
NNC	Neo Natal Care
NSV	No-Scalpel Vasectomy ["key-hole" vasectomy]
ORS	Oral Rehydration Salts
PHC	Primary Health Care
PNC	Post Natal Care
PHCC	Primary Health Care Center
STI	Sexually Transmitted Diseases
RTI	Reproductive Tract Infection
RH	Reproductive Health
UPHCP-II	Urban Primary Health Care Project
VAW	Violence Against Women
VCT	Voluntary Counseling & Tests
VIA Test	Visual Inspection with Acetic Acid (VIA)

Executive Summary

The evaluation of BCCM components was conducted with the main purpose to assess the changing knowledge, attitude, behavior and practices of urban population (adult male and female and adolescent boys and girls with representation of the poor) in comparison with baseline survey findings as well as to assess interventions of UPHCP-II interventions. During the study the service providers involved in imparting different services under the project and the community leaders who provided all out support to the project were also interviewed. Out of the total quantitative sample size of 3000 adults comprised 2350 and adolescents 650. A total of 150 in-depth (qualitative) interviews were conducted consisting of 120 service providers and 30 community leaders.

The evaluation/ end-line survey was conducted in eight selected areas. These are: Dhaka, Chittagong, Sylhet, Barisal, Khulna, Bogra, Sirajganj and Madhabdi. It may be noted that Chittagong was not included in baseline study but in this survey Chittagong was included to see its present status. The study revealed that in many aspects Chittagong area has very closer findings as in other study areas.

Adults:

During the end-line or evaluation study, the adult respondents (male: age: 18-55 years and female: 18-49) were asked about their knowledge of the UPHCP-II healthcare services, healthcare related issues, their attitude and also their health seeking behavior. Social issues like dowry, violence against women, were also included in the questionnaire and adult respondents were asked these questions to find out their knowledge on the same and exposure to this. Questions were also asked to verify their exposure to the program interventions.

The study revealed that majority adults go to pharmacy for treatment when they fall seek. They also visit other places like government hospitals, private doctor, UPHCP-II clinics, private clinics, other NGO clinics, homeopathic doctors etc. It also revealed that frequency of seeking health services from these places decreased (65.0%) among the respondents compared to baseline (80.0%) However, visiting pattern of UPHCP-II clinics increased by 6.0% in adults. This shows people are aware about UPHCP-II clinics and visiting them more for taking healthcare services. These findings are similar in pattern compared with baseline.

The healthcare seeking behavior of the community has changed through the awareness raising campaign conducted under the project and people are taking more healthcare services from UPHCP-II clinics. But the pace is very slow and changes are not significant. More adult population who live around the clinics avail healthcare services provided by these clinics. A large number of respondents visits clinics once every month.

Awareness on availability of antenatal care in UPHCP-II clinics has increased compared to baseline. Proximity of the clinics to their house is an attractive factor for visiting the clinics and frequency of visit has increased by 11.0% in adults. However, quality of services and efficiency and / or skills of doctors are still considered as important determinants by the service recipients as it was found in baseline.

^Z Œ]vP ‰ šš Œv }µš šZ o]v]•[• ŒÀ] • Z • Z vP v u}Œ neighbors and friends. So, overall knowledge and awareness and also motivation to use healthcare services from these clinics have increased to some extent a little. It is worth noting that even those who do not visit clinics also know about the existence of the clinics in their locality and about most of the services available in the clinics. These patterns are similar in both the studies.

D}•š }(šZ o]v] µ• Œ• Z À ‰}•]š]À (o]vP }µš šZ o]v] •[• C
doctors are well behaved and services are delivered cordially. Consequently, they advise their neighbors and relatives to visit the clinics for healthcare services. This has also marginally increased in end-line compared to baseline.

People of the community prefer to receive communication messages through TV and their preferred watching time is between 8 to 10 PM. This pattern is similar in both the studies.

Star Jalsha (an Indian Bengali channel) turned out to be very popular and among national channels ATN, Channel-i, BTV and few others are also frequently viewed.

Respondents have pubertal knowledge and they are aware of the physical changes during puberty. The puberty related information are received from friends and close members of family. This pattern is also similar in both the studies.

Pregnancy related knowledge is increasing, although the pace is very slow, and lot of emphasis is being given by the clinics on this issue. In the clinics, main focus is now on prenatal and postnatal cares, childcare, vaccination, acute respiratory infection and respiratory tract infection, prevention of sexually transmitted infections, and treatment is available s for these diseases. All campaign activities are centered on above issues, however, effects are still very poor on the people around.

WŒ Pv vš Á}u v Œ Á Œ }µš šZ]Œ }• v }v[š•U šZ Çe and}Á }µ
vaccination and know about hygienic way of living. It is also worth noting that during end-line study UPHCP-II clinics have been identified by the respondents as more frequently visited place for vaccination including TT vaccine. The importance of UPHCP-II clinics as the place of healthcare services have increased compared to baseline. The hygienic practices of the community people have changed. More people now use safe water and wash hands with soap/ ash after defecation compared to baseline.

Awareness of diseases like tuberculosis, STI/RTI, HIV/AIDS, gonorrhea, syphilis etc. has increased to some extent, although impact of the campaign and counseling activities is not at the expected level. The respondents know the symptoms of these diseases and also their remedies and prevention method. This pattern is similar to baseline. Some of the community people remember the contents of many campaign materials and understand the message communicated through those materials. But considering the size of respondents it is insignificant.

The respondents have clear understanding about family planning method and their uses. This is similar to baseline findings.

A small number of people in the community knows about violence against women (less than even one fourth and this is similar in both the studies) that are taking place around them. Even many of them know the law that to abuse women is a punishable offense. Most of them who know VAW is taking place around them also know the persons responsible for this and the reasons behind this. Dowry is still identified as the major cause of VAW. All these response patterns are similar to baseline study. However, one new finding i.e. considering poverty as a cause of VAW has come out of this study and it means the consequence of poverty and all that is bad associated with the VAW. This finding is new in end-line survey (poverty as cause of VAW).

The clinic users and the people around the clinic are quite familiar with the UPHCP-II logo ZZ]v }Á[}Œ
Rongdhanu, and they can also identify it with the UPHCP-II clinics.

A small section of people (end-line =15.1% and baseline=3.8%) could recall the health campaign but those who could recall can also tell about their contents, materials used and messages communicated. They could remember that those were all healthcare related campaigns and about ways of remaining in good health and living hygienic and healthy life. However, effect of campaign is very poor and needs more attention.

The respondents know about the promotional activities of the clinics. But the level of awareness is very poor and in some components it is considered changing. But those who know about the campaign could recall that they had seen posters, stickers, billboards, radio, TV and TV serials and also remember their contents and messages communicated through these advertisement materials. More extensive and effective intervention activities need to be taken in future.

Adolescents:

During this evaluation study adolescent boys and girls with age ranging from 14 to 17 were interviewed with almost similar questions asked to the adults on various healthcare issues. This was done to know about their views on healthcare services, their attitude and also their health seeking behavior, their views about social issues like VAW and dowry, proportional campaign intervention activates of the clinics etc. They expressed their views and responded to the questions without any hesitation.

The adolescents go to pharmacy (same as adults) for treatments when they fall seek, although for some common diseases. They also go to private doctors, government hospitals, UPHCP-II clinics, private clinics etc. Except UPHCP-II clinics, visit to all other places have decreased compared to baseline. This shows that boys and girls are aware of UPHCP-II clinics and this awareness is increasing.

The adolescents visit UPHCP-II clinics mainly for some common diseases and vaccination, especially TT vaccination for the girls. Most of them visited these clinics within last one month from the time of this survey. Their friends and relatives are main motivational factors for visiting these clinics. These response patterns are similar to baseline findings. It is worth noting that even those who do not visit these clinics are also aware of almost all š Z • Œ À] • ‰ Œ } À] Ç š Z o] v] • X Z o } v P Á] š] v Œ } µ v š Z o } l [v Z o o u]] v • Œ v } š À] o o [Œ š Z š Z Œ respondents still did not visit UPHCP-II clinics. Response patterns are similar to baseline.

The users of UPHCP-II o] v] • Z À P } } (o] v P } µ š š Z u X d Z Ç • Ç o] v] • [well behaved and they provide services cordially. They advise their neighbors and friends to visit the clinics and avail the healthcare services. These feelings have increased compared to baseline.

The respondents prefer to get advertising or promotional message from TV and their preferred time of Á š Z] v P d s] • š Á v ô š } í ì W D X d Z] Œ ‰ Œ (other Channels like ATN,] • Z ^ Channel-i , BTV, ETV (Ekushey TV) etc. are also the channels they prefer to watch.

The adolescent girls are aware of antenatal and postnatal care and they are also very particular about childcare and vaccination. They know about t Z] Œ } • v } v [š • v o • } l v } Á } µ š v µ and the use of nutritious foods. They are also aware of the complicacies that may arise during pregnancy and child birth. As part of child care they know about nutrition requirements of a child and the importance of timely vaccination. They also know what needs to be done in case of child diarrhea and pneumonia. They know the symptoms of these diseases and their prevention method. The response patterns are similar to baseline study.

It is also worth noting that during end-line study UPHCP-II clinics have been identified by the respondents as more frequently visited place for vaccination (37.7%=end-line) than the baseline. Earlier government hospitals found to be the mostly visited place. Now the percentage dropped by 11.2%.

Most of the respondents expressed their hygienic practices awareness by telling that they wash hands with soap or ash after defecation.

Awareness of tuberculosis and other diseases like STI/RTI, HIV/AIDS etc. has also increased to some extent compared to baseline. Those who are aware also know the symptoms and preventive mechanism. All of them have received counseling from the clinics through group meeting, courtyard meeting, counseling in static and satellite clinics etc.

Few of the adolescent respondents were found married and they were well exposed to family planning methods and knew exactly which method they were using or the reasons of not using any method.

The percentage of respondents knowing about the incidences of VAW in their locality increased in end-line (12.2%) compared to baseline (in 10.8%). Those who are aware also know that VAW or abusing women are punishable offense and the persons committing such offense. Dowry is still considered as the main cause of VAW. This response pattern is similar in both the studies.

Almost all the respondents know that dowry, (both taking and giving) is a punishable offense. This awareness level is almost the same both in male and female as was found during baseline. Majority of the respondents think that the steps which have been taken so far are sufficient. The respondents suggested that for dowry imprisonment and financial penalty both should be enacted.

Although small in number, the respondents know about the promotional activities of the clinics and the materials used for this. Those who are aware of the activities could recall seeing the posters, stickers,]o o } Œ • }vš]v]vP ZZ]v }Á >}P}[v }µo o•} Œ u u Œ šZ
messages communicated through them. Very negligible percentages of the respondents have heard the Œ]} À Œš]• u vš v Á š Z ds }uu Œ] o•l À Œš]• u vš• v šZ
The overall interventional activities could make very small impact as far as the percentage of the respondents is concerned.

Service Providers:

During this evaluation study of BCCM components of UPHCP-II, the service providers from all the study areas were interviewed at random. The respondents included doctors, paramedics, counselors and outreach workers. This was done with the same set of questionnaire used for baseline and among same categories of service providers.

The evaluation study revealed that the same method of interpersonal communication was followed by the service providers in all the centers, e.g. exchanging greetings to make them feel comfortable and seeking information regarding their healthcare status etc..

Counseling is being done on all healthcare issues like general health and hygiene, antenatal and post natal cares, child health and vaccination, diarrhea, ARI, STI/RTI, HIV/AIDS, Tuberculosis, etc. What they try to say to the community people is that instead of making things worse, they should come to clinic, take treatment and stay well. These are mostly similar to baseline.

According to the service providers women now are better equipped with the knowledge about their dos v }v[š• µŒ]vP ‰Œ Pv vÇ v (š Œ Z]o]ŒšZX dZ Ç o•} lv nutritional requirements. This increased slightly compared to baseline.

The service providers used various communication materials during counseling like, displaying different (u]oÇ ‰o vv]vP u š Œ] o•U]v oµ]vP ‰ v]•[u} oU]•‰o Ç } Œ U which was also found during baseline survey. However, they have now expanded their techniques and ‰ Œ]‰Z ŒÇX µŒ]vP šZ •šµ Ç]š Á • (}µv šZ š šZ • ŒÀ] ‰ Z}o v _ šZŒ}µPZ ‰o Ç Œ]v šZ Œ o]v U]v• š Œ]v and during courtyard meetings. They also screen documentary short film on anti-smoking campaign through projector at truck and bus stands, tea stalls etc. These patterns are similar as that of baseline.

The service providers provide counseling to various groups of people which include adolescent boys/girls, pregnant mothers, adult male/females and mothers after delivery, slum dwellers males and females, maids, day laborers, rickshaw/van puller and people of lower-middle income group. These findings are similar to baseline study. They also provide counseling in case of VAW (father and mother in-laws are counseled).

As before the service providers of UPHCP-II clinics also conduct behavior change communication (BCC) activities but their target group has increased as mentioned above. In the same way, they use leaflet, flip chart, poster, short films, miking etc. for BCC activities. Now they use more materials; hold group meetings and courtyard sessions to create awareness among people in the community. The same things used to be done earlier but now they do it with greater commitment.

It is worth noting that the entire clinic people now work as a team and unlike before, almost all the service providers who work in UPHCP-II clinics are involved in BCC activities, although this is the primary responsibilities of BCC workers and field supervisors. Now doctors, paramedics, counselors, outreach workers, BCC workers, filed supervisors, service promoters, lab assistants all are involved in rendering service to the clients.

The study has shown involvement and expansion of areas of support by the community leaders compared to the baseline findings.

The City Corporation/ municipal authority provide vaccines and the service providers implement vaccination program on different days of the week. In some clinics vaccinations are done twice in a month while at other places this program is more frequently done.

The service providers always put emphasis on delivery at hospital/ clinic and not to do it at home. Counseling is provided to the pregnant women on issues like to save money beforehand, check blood group and find a donor in case blood is needed, go to hospital/ clinic if labor pain continues for more than 12 hours and make arrangement for transport in advance. The service providers of all PHCCs refer delivery cases to CRHCC because full time ambulance service and gynecologist are available in CHRCCs. In CRHCCs both normal and Caesarian delivery and other support services are available. The service providers arrange ambulance when patients need to be transferred to a CRHCC. The response pattern and types of activity have similarity in both the studies.

During the study, the respondents said that they provide different types of family planning related information to the clients.

Information is usually disseminated through group meeting, courtyard session, visiting households, leaflet, flip chart, slide show, and in static clinics through counseling. dZ ds Œ u • Œ] o ^' Œ] Z}

been added as a new way to aware people about healthcare. During the current study the service providers told about many new method areas of information dissemination and motivation that they use e.g. courtyard meeting, door to door visit, and also sitting in clinics. They also explain the importance of drinking safe water and also the benefit of maintaining personal hygiene. All these are done the same way as before but with more commitment.

Category-wise, service providers had undergone training on many topics as under:

- **Doctor:** HIV/AIDS, RTI/STI, TB, obstetric care, neonatal care, nutrition, infection prevention, clinic management, swine flu, EPI, implant, VIA test, counseling, violence against women, reproductive health, blood transfusion, Primary Eye Care, rational usage of drugs, quality assurance and quality of care, Family Planning, gender, adolescent reproductive health, interpersonal communication, O.T management, M.R., message development leadership, youth friendly.
- **Counselor:** BCC, family planning, Primary Eye Care, Family Planning, breast feeding, ANC, PNC, HIV/AIDS, RTI/STI, EPI, violence against women, adolescent health, TB, Documentation, safe delivery, adolescent reproductive health, interpersonal communication, ECP and childcare.
- **Outreach worker**: Nutrition, EPI, HIV/AIDS, Clinic promotion. STI/RTI, BCC, Primary Eye Care, Family Planning, ANC, PNC, Violence against women, reproductive health, adolescent health, child healthcare, diarrhea, interpersonal non-verbal communication, gender, peer education, TB, infection prevention, ARI, counseling and conducting health session.
- **Paramedic**: Septic abortion, infection prevention, VIA test, gender, primary eye care, family planning, emergency obstetric care, interpersonal communication, M.R., clinic management, EPI, BCC marketing, counseling, VCT, HIV/AIDS, STI/RTI, growth monitoring, TB, adolescent reproductive health, implant, gender, IMCH (Integrated Maternal and Child Health) , MCH, PECI, safe delivery, NNC, NSV, ORS, ANC/PNC, and IUD.
- **Field Supervisor:** BCC, STI/RTI, HIV/AIDS, Nutrition, violence against women and EPI.
- **BCC worker:** BCC, violence against women, counseling, EPI and eye care.
- **Service promoter:** Primary Eye Care, Family Planning, HIV/AIDS, RTI/STI and TB.
- **Nurse:** Child and mother healthcare, diarrhea, ARI, HIV/AIDS, breast feeding, nutrition, Menstrual Regulation (MR), STI/RTI, VIA test, family planning, EPI, interpersonal communication.

Community Leaders:

During evaluation study community leaders of different profiles were interviewed. They were Councilor of City Corporation/ Municipality, businessmen, teachers, housewives and service holders. The findings from these interviews revealed that on an average the response patterns are similar to baseline findings.

The evaluation study reveals that the community leaders are well aware of and well exposed to the UPHCP-II o]v] •[š]À]š] •U • u • (}Œ ~ • o clinics. Mainly services are given to pregnant women, and services related to vaccinating children, family planning etc. is also provided. They also know that the clinic provides services to poor and ultra poor people (red card holders), people of low income group, adolescent boys and girls, pregnant women, victim of VAW tortured women and to all other community people in their catchments area.

Similar as the baseline findings this study also reveals that the community leaders motivate people in their area to take healthcare services from UPHCP-II clinics.

During the evaluation study, it was found that the community leaders were aware about the BCC campaign conducted by UPHCP-II clinics. The community leaders know that these are done by the clinics through courtyard session, group meeting with adolescent boys and girls, Door to door campaign, counseling, flip charts, screening drama serial ^' Œ] Z}o v _ šZŒ}µPZ ‰o Ç ŒU ‰}
etc.

The community leaders said that the clinics carry out BCC campaign on various issues like immunization of children and reproductive age women, ANC, PNC, safe delivery, advantage of having small family, adolescent reproductive health, changes during puberty, child marriage, nutrition, nutritious food for children, maintaining personal hygiene, use of sanitary and hygienic latrine, hand wash with soap or ash after defecation, before eating food and feeding baby, use of safe and pure drinking water, STI/RTI, HIV/AIDS, and many other healthcare topic. The response patterns are similar like the baseline.

The evaluation study reveals that participation of the Community Leaders has increased in all study areas. dZ Ç šš v o]v] o À]•}ŒÇ }uu]šš D š]vP v }uuµv]šÇ > Œ
clinics. In these meetings community leaders discuss with the service providers of UPHCP-II clinics about how to motivate more people to avail the healthcare facilities provided by the UPHCP-II clinics. The study also shows that the community leaders think that they play vital roles to ensure the quality of services provided by the service providers of UPHCP-II clinics. The findings are similar to the baseline however now they do it with greater commitment.

The community leaders play a vital role for the sustainability of the UPHCP-II clinics. They usually motivate common people to avail different services provided by the clinic. On many occasions the community leaders also visit the clinic to boost up the moral of the stuff and also give them moral and social support so that they perform well.

The study finds that the community leaders provided several suggestions about reducing gender discrimination. These are: giving importance to women in family, providing higher education to girls, not to marry girls in early age, making women self-reliant, not to discriminate between boys and girls, implementing law to prevent VAW, increasing quota in job for women, increasing social security for women, increasing mass awareness on these issue, creating more jobs for women etc. Compared to baseline, the present study reveals that the community leaders are taking more initiatives to create awareness among the community people so that they do not discriminate between boys and girls, and men and women. The commitments of the community leaders were found more as compared to baseline.

They help establish community based resistance committee against such violence, create more employment opportunities for women, and take initiative to educate women and to make them self-reliant. They also help conduct policy level campaign to create awareness through mass media addressing issues like avoiding early marriage, preventing use of drugs, increasing literacy rate, proper implementation of laws related to VAW and dowry, and that any act of violence against anybody is illegal and a punishable offense. They provide support in holding meetings in neighborhoods or parasand wards or mohollasand develop awareness regarding consequence of VAW and help people understand that committing such crime is a punishable offense.

During the evaluation study, the community leaders were asked about the intervention activities. These aŒ ‰}•šŒ•U ^š]lŒU]oo}ŒUZ]}U do À]•]}v v ds•Œ]o ^
seen the poster, the stickers, and the billboard containing rainbow logo. The community leaders were also had listened to any advertisement in radio, had seen any advertisement in television on Urban Primary , ošZ Œ všŒ v ÁŒ v Z • všZ ds•Œ]o v ^'Œ] Z}o

Conclusion:

The evaluation study of BCCM components were carried out to assess the varying knowledge, attitude, behavior and practices of urban population (adult male and female and adolescent boys and girls) including the poor) in comparison with baseline survey findings as well as to assess interventions of UPHCP-II interventions.

It was seen that the people are more aware about the UPHCP-II healthcare centers and its services, especially the target women now know more about what they should do and what they should not do during pregnancy and after delivery, about child care, nutrition requirements for their own and the children including the importance of timely vaccination of their children. All these mean that the counseling activities and campaigning activities and intervention activities had a positive effect on the community people around the clinics.

Community people also are now better equipped with knowledge about many diseases like diarrhea, ARI, Pneumonia, STI/RTI, HIV/AIDS/Gonorrhea, Syphilis/ Tuberculosis, etc. Not only that but they also know the symptoms of these diseases and their prevention mechanism.

Social awareness is rising about violence against women and dowry and people now know that these are punishable offenses. They also suggested various punishments once these crimes are committed.

Impact of the project intervention was found to be very effective and produced good results. However, the campaign coverage need to be widened and more and more people should be involved to create greater impact.

It was amazing to notice that counseling service is not confined now as the responsibility of the ^ }µv• o}Œ•_ }vo Ç Œ šZ Œ }šZ Œ o]v] •š ((U]ŒŒ •‰ š]À }(šZ] as required to maximize the benefit of the clients.

The overall finding is that health related knowledge of the target population is increasing, especially about maternal and child health; their health service seeking behavior is also changing positively. However, the change is not always that visible due to its slow pace. Yet practices have been limited to accessibility of service and cost and time involved, as for these reasons still many people do not visit the clinics.

Recommendation:

Considering the study findings, it can be recommended that more of such programs need to continue. A joint initiative by the government and the non-government organizations can produce excellent and tangible results.

Z vP]vP ‰ }‰o [• šš]šµ v Z À]}Œ]• Z oo vP]vP š •lX /v u good results. Sometimes, the findings are very similar to the baseline study. However, there are areas where the study findings are not at the expected level, e.g. visiting of UPHCP-II clinic by people around was not increase notably as compared to base line, as explained in details in the last chapter of this report. These need close attention and more extensive efforts are required to make noticeable improvement in these areas. Maximum importance need to be given to campaign and intervention activities to increase healthcare awareness among community people more significantly. There should be more programs like this in the country with more intensive BCC activities.

Chapter 1

Introduction

1.1 Background

The goal of UPHCP-II is to improve the health status of the urban population, especially the poor, through improved access to and utilization of efficient, effective and sustainable Primary Health Care (PHC) services. At least 30% of each of the services provided under the Project will be targeted to the poor. The objectives of UPHCP-II are to improve equitable access and utilization of urban PHC services in the project area with a particular focus on extending provision to the poor.

The UPHCP-II project has four components, which were designed through intensive national and local consultations with key stakeholders taking into account the needs of the poor and vulnerable population. The components are:

I. Provision of Primary Health Care through Partnership Agreements and Behavioral Change Communication

II. Strengthening the urban PHC infrastructure and environmental health

III. Strengthening local stakeholder communication capacity, advocacy, and policy support for urban PHCs.

IV. Project implementation and operationally relevant research.

The project includes:

- Modified ESP+ services including immunization and growth monitoring of children; micronutrient support and malnutrition; family planning; prenatal, obstetric and postnatal care with special attention to prevent Eclampsia, STI and HIV/AIDS, other Reproductive Health (RH), child health. The Service also includes systematic case management of pneumonia and diarrhea in children; health education; sanitation, safe water and waste disposal; case management and services dealing with tuberculosis, leprosy, malaria, filarial, kala-a-zar; management of emergency cases (bites, drowning, accident, cut, burn, choking epidemics, etc.); with greater emphasis on nutrition, equity and gender issues, assistance to victim of Violence Against Women (VAW), injury, primary eye care, mental health, etc.
- Extensive BCC to both ensure that the general population, especially the poor people (red cardholders) are encouraged to adopt home-based health behavior as well as health service seeking behavior, with an emphasis on the UPHCP-II services.
- Special mobilization activities to ensure that the people, especially the poor in six CCs plus some selected municipalities of the country get access to UPHCP-II service sites/facilities.

The three subcomponents of BCCM is (i) Infectious disease, RTI/STI and HIV/AIDS control, (ii) Environmental health and (iii) Other ESP and nutrition- related behavior change.

Within the context of ESP and urban PHC, specifically focused on urban poor, women, children and adolescent girls, the consultant (firm/ institution) would increase their knowledge, stimulate community] o } P µ Á] š Z š Z ‰ Œ } À] Œ • v ‰ Œ } À] Œ u v P u v š š } Æ Œ š š services, promote essential attitude change among providers and health seeking behavior among people t the poor, create a demand for dignified services, advocate among policy makers and especially opinion

leaders for organizing community supported services, e.g. EOC. RH, etc, promote service for prevention, care and support, improve skills and sense of self-efficacy among providers.

The BCCM activities should lead to significant increase in awareness of maternal and childcare, environmental health, safe sex, HIV/AIDS and STI prevention, nutrition and disease prevention among the urban population served by the project.

1.2 UPHCP-II Working Areas

City Corporations (CCs)	Municipalities
X Dhaka	X Savar
X Chittagong	X Comilla
X Rajshahi	X Bogra
X Khulna	X Sirajganj
X Barisal	X Madhabdi
X Sylhet	

1.3 Purpose of the Evaluation Study

The main purpose of the evaluation study is to assess the changing knowledge, attitudes, behaviors and practices of urban population (adult- male and female and adolescent- boys and girls), with representation of the poor comparing with baseline as well as to asses all interventions of UPHCP-II.

1.4 Objectives of the Evaluation Study

The objectives of this evaluation are to collect and analyze information of the population to assess the changing knowledge, attitudes, behaviors and practices of the adults and adolescents comparing with baseline on the following areas:

1. To assess level of awareness on modified ESP^{+} services provided through Urban Primary Health Care Centers
2. To measure the extent on necessity of immunization and growth monitoring process of children
3. To measure level of awareness on micronutrient support and malnutrition
4. To identify level of awareness on family planning, prenatal, obstetric and postnatal care with special attention to prevent Eclampsia
5. To examine the knowledge on RTI/STI, HIV/AIDS, and other Reproductive Health (RH) related problems
6. To assess level of understanding on child health including systematic case management of pneumonia and diarrhoea in children
7. To identify level of awareness on sanitation, safe water and waste disposal, case management and health education is provided through the services of UPHCP-II
8. To assess the effectiveness of available services dealing with tuberculosis, leprosy, malaria, filarial, kala-a-zar, management of emergency cases, with greater emphasis on nutrition, equity and gender issues especially assistance to victim of Violence Against Women (VAW), injury, eye diseases, mental health, smoking, etc.

9. To assess the effectiveness of BCC campaign among general population, especially the poor people are encouraged to adopt home-based health behavior as well as health service seeking behavior, with an emphasis on the UPHCP-II services
10. To assess the effectiveness of special mobilization activities to ensure that the people, especially the poor in City Corporations and some selected large municipalities of the country get access to UPHCP-II service sites

1.4.a Objectives to Assess Intervention Activities

- To assess the knowledge and skill of service providers on BCCM and counseling
- To identify the exposure of UPHCP-II clinics and services provided from UPCHP-II clinic and UPHCP-II branding
- To know the extent of exposures for different communication interventions and messages
- To assess the reaction on seeing different communication materials such as poster, stickers, TV & radio spots, billboard, etc.
- To examine whether BCC materials are properly used by clinics and its activities conducted at local and national levels
- To assess how many household have watched TV serial t ^ ' Œ] Z o v _

1.5 Survey Approach

The main data collection activities were carried out at the following levels:

- Individual level (Potential Clients): Detailed information was collected from both the existing and potential clients of the households, which include adult male (age 18 - 55 years) and adult female (age 18 t 49 years); and Adolescent boys and girls (age 14 - 17 years)
- Primary Health Care Center level (Service Providers): Information was collected from the PHC service providers about their services, their attitudes towards potential service recipients and opinion on the behavior and practices of the service recipients.
- Community level (Local Leaders): Information was collected from the community leaders on their attitude towards PHC services provided by respective service providers under UPHCP-II.

To achieve the study objective, by keeping in line with the above study approach, both qualitative and quantitative methods was followed. Following chart shows broad information-wise sources and technique:

Information Area	Source	Technique
Individual (Potential Client) Level	Adult male (age 18- 55 years) and Adult female (age 18-49 years) including people from poor socio-economic background; and Adolescent boys and girls (age 14- 17 years)	Quantitative
Primary Health Care Center level	Service providers under UPHCP-II working areas (Doctors, Paramedics, Counselor and Outreach Workers)	Qualitative (In-depth interview)
Community level	Community Leaders (Ward Councilors, Teacher, Housewives, Businessman, Service Holders etc.)	Qualitative (In-depth interview)

1.6 Indicators/ Information Coverage

During the survey following indicators/information were covered.

Individual/ household (potential client) level

- Family size with age, sex, education and occupation of the family members
- Status and structural condition of the dwelling house
- Level of knowledge about location of health facilities in the locality e.g., UPHCP-II clinics (PHCs and CRHCC)
- Level of awareness about services available at UPHCP-II and attitudes towards their services
- Level of awareness on necessity of immunization and growth monitoring process of children.
- Level of awareness on micronutrient support and malnutrition.
- Level of awareness on family planning, prenatal, obstetric and postnatal care with special attention to prevent Eclampsia
- Level of knowledge on STI, HIV/AIDS, and other Reproductive Health (RH) related problems
- Level of understanding on child health including systematic case management of pneumonia and diarrhea in children
- Level of awareness on sanitation, safe water and waste disposal, case management and health education is provided through the services of UPHCP-II
- Level of effectiveness of available services dealing with tuberculosis, leprosy, malaria, filarial, kala-a-zar, management of emergency cases, with greater emphasis on nutrition, equity and gender issues especially assistance to victim of Violence Against Women (VAW), injury, eye diseases, mental health, smoking, etc.
- Level of effectiveness of BCC campaign among general population, especially the poor people who were encouraged to adopt home-based health behavior as well as health service seeking behavior, with an emphasis on the UPHCP-II services
- Level of effectiveness of special mobilization activities to ensure that the people, especially the poor in City Corporations and some selected large municipalities of the country get access to UPHCP-II service sites.

The following BCC related information was collected from individual/ household respondents:

- Level of exposures for different communication interventions and messages
- Level of reaction on seeing different communication materials such as poster, stickers, TV & radio spots, billboard, TV serials etc.
- Use of BCC materials by clinics and the related activities
- To assess how many household have watched TV serial t ^ ' Œ] Z o v _

Service providers level

- Knowledge and skill of service providers on BCCM and counseling
- Exposure of UPHCP-II clinics and services provided from UPCHP-II clinic and UPHCP-II branding

Community leaders level

i) Knowledge, Attitude and support towards the following:

- ESP services
- BCC campaign for general population
- Community mobilization through network approach and tools
- Incidence of violence against women

ii) Community attitude towards poverty and gender issues and support to the poor adults and adolescents (male and female).

1.7 Working Definition of Poor

In this evaluation survey, poor people was defined as per the criteria followed for identifying the urban poor in the baseline survey of KABP in UPHCP-II working area, based on a combination of living conditions, nature of empowerment, monthly income, house rent, and food intake. For this study people living in ordinary slums, nature of employment is casual and who are informal sector workers, who take two adequate or three inadequate meals per day, who may be widow, member of women headed households, migrants from rural areas in the last two years will be taken as poor.

1.8 Detailed Methodology

1.8.1 Methods

Both qualitative and quantitative surveys were conducted. The study involved primary surveys, including one - on - one interview and In-depth Interviews. Information source-wise method was as follows:

Information Source	Technique/ Method
Individuals (Potential Clients): Adult male (age 18 - 55 years) and Adult female (age 18 - 49 years) including people from poor socio-economic background; and Adolescent boys and girls (age 14 - 17 years)*	Quantitative
PHC service providers under UPHCP-II (Doctors/ Paramedics and BCC Outreach worker)	Qualitative In-depth interview
Community Leaders (Ward Councilors, Teachers, Housewives, Businessmen, service holders etc.)	Qualitative In-depth interview

*Since this is an end-line survey the age of adolescent audience was taken from the baseline specification. There lower age limit was 14 years instead of 10 because there are many study topics which are not relevant for that age (10+) and respondents of that age cannot articulate their responses.

Ethical issues: Before commencement of actual interview, the interviewers properly introduced themselves and the organization to the respondents. They explained the purpose / objective of the study. They assured the respondents that their identity would not be disclosed and confidentiality of information received from them will be maintained and these would be used for research purpose only. This issue can be seen from the attached questionnaires.

1.8.2 Sample Size and Distribution

Considering statistical technique to determine representative sample size, a total of 3000 potential respondents (adult and adolescents) were selected from the study areas for quantitative part of the study. In addition to this, total number of 150 respondents was also selected both from Service Providers (120) and Community Leaders (30) for qualitative part of the study.

Rationale for proposed sample distribution: Sample was distributed in such a manner to ensure sample adequacy for making center-wise analysis, keeping in line with the baseline survey. The final achieved sample size for the end-line study was as follows:

Sample distribution of adults and adolescents

Table- 1: Sample distribution of adults and adolescents

Sl. No.	Center	*Adults (male- age:18-55 and female- age: 18-49)			Adolescent (age:14-17 years)			Total
		Male	Female	Total	Male	Female	Total	
1	Dhaka	125	375	500	50	50	100	600
2	Chittagong	100	300	400	50	50	100	500
3	Sylhet	69	206	275	38	37	75	350
4	Barisal	56	169	225	38	37	75	300
5	Khulna	69	206	275	37	38	75	350
6	Bogra	56	169	225	37	38	75	300
7	Sirajgonj	56	169	225	38	37	75	300
8	Madhabdi	56	169	225	37	38	75	300
Total		**587**	**1763**	**2350**	**325**	**325**	**650**	**3000**

Note: In adult group, Females (18-49) were interviewed separately. They are adult, married, reproductive females. In every alternative 3 females, their husbands were interviewed (Husbands in the table/Figure), and both husband and wife were interviewed separately.

Sample distribution [service providers and community leaders]

Table- 2: Sample distribution [service providers and community leaders]

Center	Service Provider					Community Leader	Total
	Doctor	Paramedic	Counselor	Outreach Worker	Total		
Dhaka	4	4	4	3	15	4	19
Chittagong	4	4	3	4	15	4	19
Sylhet	4	3	4	4	15	4	19
Khulna	3	4	4	4	15	4	19
Barisal	4	4	4	3	15	4	19
Bogra	4	4	3	4	15	4	19
Sirajganj	4	3	4	4	15	3	18
Madhabdi	3	4	4	4	15	3	18
Total	**30**	**30**	**30**	**30**	**120**	**30**	**150**

Note: We know that Chittagong was not included in baseline survey on KABP in UPHCP-II working areas. Therefore, in this study for Chittagong, only the present status of KABP has been reflected.

1.8.3 Sampling Technique

a) Sampling technique for quantitative study:

Since this study is an evaluation of the baseline survey done earlier, similar sampling techniques was adopted and same list of clusters was used which was used during baseline survey. During this evaluation survey of BCM components in UPHCP-II, the same sampling technique and break-up method for wards and clusters as under was followed proportionate to the sample size:

Sample Distribution

Table- 3: Sample distribution

	Center	No. of Wards	No. of Cluster per Ward	Total Cluster	No. of interview per Cluster	Total interview
1	Dhaka	10	4	40	15	600
2	CTG	9	8=4, 1=2	34	33=15, 1=5	500
3	Sylhet	6	4	24	23=15, 1=5	350
4	Khulna	6	4	24	23=15, 1=5	350
5	Barisal	5	4	20	15	300
6	Bogra	5	4	20	15	300
7	Sirajgonj	5	4	20	15	300
8	Madhabdi	5	4	20	15	300
	Total	**51**		**202**		**3000**

In order to make the study representative of the district stratified multistage random sampling technique was used as described below:

- Stage t1: Select approximately adequate number of wards under each of the municipalities based on the location of PHCs. The ward was selected randomly.
- Stage t2: Select required number of cluster for survey area. The clusters were also selected randomly. All slums, poor areas and low socio-economic areas within 2 sq kilometers of each PHC were selected.
- Stage t3: Selected households to conduct survey in the selected clusters.

Selection of households and respondents amongst the potential clients:

Principle: Not more than one respondent was interviewed from the same household. Leaving two households both husband and wife from the third household was interviewed.

- Households were selected by following systematic random sampling technique.
- A pre-determined number of Starting Points (SP) was selected in each location randomly. Around each randomly selected starting point/cluster, a predetermined number of households were contacted and interviewed.
- The Right Hand Rule was used for selection of households other than the Starting Point (SP) household. This rule states that after reaching the SP, the investigator needs to go to the households falling on the right hand side.
- Male interviewers interviewed the male respondents and female interviewers interviewed (u o •[Œ • ‰ } v v š • X

b) Sampling technique for qualitative study:

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Selection of respondents from service providers level:

Doctor, Paramedic, Counselor and Outreach Workers from some selected PHC within UPHCP-II working areas were selected to collect information on available services provided by them.

- Wards were selected randomly.
- Under each ward, required number of clinics were selected by systematic random sampling
- From each clinic, respondents were selected by purposive random sampling

Selection of respondents from community level:

Ward Councilors, Teachers, Housewives, Businessmen, Service Holders were selected for in-depth interview to collect information on the attitude of the community.

- Wards were selected randomly
- Under each ward, required number of clinics were selected by systematic random sampling
- The respondents were selected mainly from the members of advocacy committee
- Some of the respondents were selected by purposive random sampling, keeping the clinic as the base and those who live around the clinics

1.8.4 Data Collection

Experienced and properly trained field interviewers conducted all interviews. A minimum 15% of the interviews were back-checked and the field supervisor accompanied at least 5% of the interviews and covered all the enumerators working under him/her. The field consisted of several teams. Each team included a field controller. Field controllers reported to the field manager. In total, there were 48 enumerators, 6 supervisors, 6 controllers and 1 field manager.

1.8.5 Analysis Plan

Both the quantitative data and qualitative data were compared with the data of baseline survey, against the indicators. Comparisons have been shown both in textual interpretation and graphical/tabular presentation as applicable.

Quantitative data: The responses were analysed as per agreed analysis plan. Data entry package namely FoxPro was used for data entry. Data analysis was carried out by using SPSS. The tabulation and analysis plan were prepared similar to baseline. However, in general, analysis of data on potential client level was done by total, municipality (City Corporation or Municipality), socio-economic class, etc. for each of the variables/ indicators covered by the study. Besides, data was also analysed by age, education, poor tpro-poor etc. where applicable etc.

Qualitative data: Data collected by using qualitative technique was essentially content analyzed. Responses of In-depth Interviews were recorded and contents were analyzed.

1.8.6 Project Implementation:

a) Questionnaire:

As it is an evaluation survey, the same set of questionnaires (both for individual interview and in depth interview) was used which were used for baseline survey.

b) Training:

Field interviewers were trained properly before going to the field for data collection.

c) Collaboration with implementing NGOs:

The survey was conducted in collaboration with selected local implementing NGOs (where necessary), who were responsible for implementing in the UPHCP-II program and are familiar with working areas.

Final selection of FI and FS was done on the basis of the practice interview and mock test results. Second round of briefing/ training will be done after final selection.

d) Administration of fieldwork/ quality control:

Experienced and properly trained field interviewers conducted all interviews. A minimum 15% of the interviews were back-checked and the field supervisor will accompany at least 5% of the interviews and cover all the enumerators working under him/her.

e) Quality control:

Data collection quality ensured through stringent quality control mechanism by multiple steps as follows:

Stringent recruitment and training of field personnel:

Thorough recruitment and training procedure was followed, as explained earlier.

Back-checks and scrutiny:

A thorough and random back-check procedure was followed to ensure quality fieldwork in the following manner:

- Accompany call 5%
- Application of sampling plan 15%
- Sample verification 15%
- Response verification 10%
- Scrutiny and editing 100%

Corrective actions were taken immediately if found any gaps or deviation.

f) Central monitoring cell:

Compilations of successful interviews were done centrally by the monitoring cell to monitor the progress of data collection. Additional resources were deployed to complete the task in time as required.

1.9 Data Entry, Processing and Analysis

ORG-QUEST Research Ltd. was responsible for data entry, cleaning, processing and analysing data. Data processing involved the following stages under the guidance of the EDP manager who worked in close co-ordination with the researchers handling the project. Data entry form was designed by using Visual Foxpro. Data processing and analysis were done by SPSS.

Chapter 2

Findings from Adult Respondents

2.1 Socio-Demographic Characteristics of Respondents

This section reflects the socio-demographic characteristics of the adult respondents i.e. female, wives and husbands e.g. their age, literacy status, occupation, monthly income, house rents etc.

A total of 2,350 adult respondents were interviewed in the eight study areas (Dhaka, Sylhet, Barisal, Khulna, Bogra, Sirajganj, Madhabdi and Chittagong) of Bangladesh. Among them 1,763 were females. Out of the total female respondents, 1176 were interviewed alone in their households and rest 587 were wives in every third household whose husbands were also interviewed but separately. Therefore, the number of husbands and wives interviewed is equal. The detailed breakdown of respondents and study sites was as follows.

Table- 4: Distribution of adults by category and study sites (percent)

	Dhaka	Sylhet	Barisal	Khulna	Bogra	Sirajgonj	Madhabdi	Chittagong	All (Average)
Husband	25.0	25.1	24.9	25.1	24.9	24.9	24.9	25.0	25.0
Wife	25.0	25.1	24.9	25.1	24.9	24.9	24.9	25.0	25.0
Female	50.0	49.8	50.2	49.8	50.2	50.2	50.2	50.0	50.0
Base- all respondents	**500**	**275**	**225**	**275**	**225**	**225**	**225**	**400**	**2350**

Age group:

In the end-line, largest segment (25.3%) of adults respondents were in the age group of 18 to 24 years followed almost equally by age group of 25 to 29 years (25.2%) and age group of 30 to 34 years (17.7%). The average age of the respondents has remained very similar in both baseline and end-line surveys (Table 5). For both of the baseline and end-line survey, the minimum age of adult respondents was 18 years. In the baseline survey, largest segment (25.8%) of adult respondents was in the age group of 25 to 29 years, followed by age group of 18 to 24 years (21.6%).

Table- 5: Distribution of adults by age (percent)

	Female*		Husband**		Wife***		All (Average)	
	End line	Base line	End line	Base line	End line	Base line	End line	Base line
18-24	33.0	27.2	3.9	3.0	31.2	28.9	25.3	21.6
25-29	24.6	26.8	22.0	20.1	29.6	29.4	25.2	25.8
30-34	17.2	20.7	21.3	19.4	15.3	20.1	17.7	20.2
35-39	13.9	17.4	18.1	25.1	13.3	15.1	14.8	18.8
40-44	8.2	5.6	15.5	17.7	7.8	5.0	10.0	8.5
Above 45	3.1	2.3	19.3	14.7	2.7	1.5	7.1	5.2
Average	28.3	28.9	35.5	35.4	28.2	28.3	30.1	30.4
Base-all respondents	**1176**	**924**	**587**	**463**	**587**	**463**	**2350**	**1850**

*Female: Female interviewed separately; **Husband; ***Wife: Couples but interviewed separately

Education:

In the end-line, out of the total adults respondents more than half (53.9%) had read class IX. Among husbands and wife, this percentage was almost similar. As compared to the husbands, the percentage of schooling for females was slightly high. However, a very few number of males had higher education level compared to the wives and females, but, less proportion of males had primary education as compared to wives and females. Details can be seen in the table below.

In the achieved sample size, there were differences in literacy status of the adult respondents, during end-line and baseline surveys. For example, the illiterate respondents were 37.6% in end-line as against 30.8% in baseline.

Table- 6: Distribution of adults by education (percent)

	Female		Husband		Wife		All (Average)	
	End line	Base line	End line	Base line	End line	Base line	End line	Base line
Illiterate	37.2	29.0	38.5	33.5	37.5	31.8	37.6	30.8
Literate but no formal schooling	3.0	0.9	3.8	1.5	2.4	0.4	3.0	0.9
Up to Class V	28.2	28.0	24.4	22.0	26.9	28.1	26.9	26.5
Class VI t Class IX	23.9	30.5	20.6	23.5	23.0	25.1	22.9	27.4
S.S.C	5.5	6.7	6.0	10.6	7.2	8.4	6.0	8.1
H.S.C	1.9	2.9	4.8	4.3	2.4	5.0	2.7	3.8
Graduate	0.3	1.5	1.4	3.0	0.7	0.9	0.7	1.7
Post Graduate	0.0	0.4	0.7	1.5	0.0	0.4	0.2	0.7
Base-all respondents	**1176**	**924**	**587**	**463**	**587**	**463**	**2350**	**1850**

Occupation:

The population by their occupation in both the end-line and baseline are similar. Single largest portion of the respondents in end-line survey were small traders (apporx.24.0%) and this percentage was highest in Bogra i.e. around 28.0%. Details can be seen in the table below.

Table- 7: Occupation of the Respondents Figure in %

	Dhaka		Sylhet		Barisal		Khulna	
	End line	Base line	End line	Base line	End line	Base line	End line	Base line
Small traders	23.7	25.5	22.9	15.6	22.3	18.6	18.9	21.4
Rickshaw puller/ Rickshaw Van puller	21.8	11.2	19.1	18.6	17.3	9.2	9.4	19.0
Day laborer	14.3	9.2	11.4	11.2	16.0	4.4	13.1	9.8
Factory workers	5.5	3.5	1.7	2.7	7.0	8.8	12.9	11.9
Shopkeepers	2.3	1.5	4.3	5.4	6.7	7.5	5.1	5.1
Mason/Welder/ Color/technician/Carpenter	1.0	6.0	7.7	10.5	6.0	5.8	9.7	4.4
Taxi/Bus/ Private car drivers	6.7	5.0	2.3	2.4	1.7	2.0	3.4	4.4
Baby Taxi or Tempo drivers	3.0	2.8	5.4	2.4	3.3	0.0	3.4	0.3
Garments worker	8.2	4.2	0.0	0.7	0.3	0.7	0.0	1.4
Others	**13.5**	**31.2**	**25.1**	**30.5**	**19.3**	**43.1**	**24.0**	**22.4**
Base-all respondents	**600**	**600**	**350**	**295**	**300**	**295**	**350**	**295**

Occupation of the Respondents (continued) Figure in %

	Bogra		Sirajgonj		Madhabdi		Chitta-gong	All (Average)	
	End line	Base line	End line	Base line	End line	Base line	End line	End line	Base line
Small traders	28.3	28.1	21.0	19.8	26.3	19.3	27.0	23.9	21.8
Rickshaw puller/ Rickshaw Van puller	9.7	4.4	21.0	20.5	8.7	4.9	11.4	15.3	12.4
Day laborer	8.3	7.1	14.3	9.5	3.3	7.4	11.6	11.9	8.5
Factory workers	9.3	2.0	6.0	1.1	29.3	20.7	10.8	9.8	6.7
Shopkeepers	5.7	10.5	4.0	3.9	8.3	8.1	9.8	5.7	5.4
Mason/Welder/Color/ technician/Carpenter	3.3	2.0	7.3	3.5	5.0	7.4	2.2	4.8	5.7
Taxi/Bus/ Private car drivers	3.7	2.4	4.7	1.4	2.0	0.0	5.0	4.0	2.9
Baby Taxi or Tempo drivers	0.7	0.7	0.3	0.4	1.0	0.7	3.6	2.8	1.3
Garments worker	0.0	0.0	1.0	0.0	3.7	0.4	3.4	2.7	1.4
Others	31.0	42.7	20.3	40.6	12.3	31.2	15.2	19.3	34.0
Base-all respondents	**300**	**295**	**300**	**285**	**300**	**285**	**500**	**3000**	**2350**

Monthly income:

There were no noticeable differences on the monthly income status of the adult respondents during the end-line and baseline surveys. &}Œ Æ u‰o U u}•š }(Œ •‰}v vš•[(u]oÇ]v }u -Á • (}µ 5000, Taka 5001-7000 and Taka 7000-10,000 in end-line survey. Across the centers, the income range of families varies.

Table- 8: Distribution of family monthly income (percentage of adults by study sites)

	Dhaka		Sylhet		Barisal		Khulna	
	End line	Base line	End line	Base line	End line	Base line	End line	Base line
Below 1000	0.0	0.0	0.7	0.0	1.3	0.0	0.4	1.3
TK.1001 t2000	0.4	0.2	0.0	1.8	2.7	0.0	2.5	3.6
TK.2001 t3000	1.4	7.2	1.8	4.9	9.3	9.8	10.2	29.3
TK.3001 t4000	4.8	8.6	4.7	13.3	16.0	13.8	16.4	25.8
TK.4001 t5000	12.8	18.8	14.2	36.0	24.9	21.8	24.7	13.8
TK.5001 t7000	23.8	31.8	38.9	24.0	20.4	26.7	23.3	12.4
TK.7001 t10000	32.2	18.0	25.8	16.4	21.8	23.6	12.0	12.0
Above TK. 10000	24.6	15.4	13.8	3.6	3.6	4.4	10.5	1.8
Base	**500**	**500**	**275**	**225**	**225**	**225**	**275**	**225**

Distribution of family monthly income (Continued) (percentage of adults by study sites)

	Bogra		Sirajgonj		Madhabdi		Chitta-gong	All (Average)	
	End line	Base line	End line	Base line	End line	Base line	End line	End line	Base line
Below 1000	1.8	0.0	0.0	0.0	1.8	0.0	0.8	0.7	0.2
TK.1001 t2000	3.6	1.3	0.9	0.0	0.4	0.4	0.3	1.1	0.9
TK.2001 t3000	16.9	11.1	7.6	10.2	1.8	3.1	1.8	5.4	10.3
TK.3001 t4000	20.4	15.6	12.0	24.9	9.3	16.9	6.8	10.2	15.7
TK.4001 t5000	24.0	20.9	24.9	28.9	22.7	33.8	23.5	20.5	23.9
TK.5001 t7000	12.9	22.7	27.6	22.7	21.3	17.3	27.0	24.8	23.9
TK.7001 t10000	16.4	20.0	19.1	12.9	24.0	21.8	32.5	24.6	17.8
Above TK. 10000	4.0	8.4	8.0	0.4	18.7	6.7	7.5	12.6	7.2
Base	**225**	**225**	**225**	**225**	**225**	**225**	**400**	**2,350**	**1,850**

Housing status:

More than half of the respondents live in rented house (62.0%) shown in the following table. The highest rate (82.0%) of respondents Chittagong live in rented house and this percent was lowest was found in Sirajganj (5.8%).

The housing status of the respondents in both the baseline and the end-line are quite similar. However, the ratio of staying in others house/on government plots (no rent required) in Sirajganj and Dhaka were significantly higher as compared to the baseline.

Table- 9: Housing status (percentage of adults by study sites)

	Dhaka		Sylhet		Barisal		Khulna	
	End line	Base line	End line	Base line	End line	Base line	End line	Base line
Own House	7.2	17.6	15.6	21.3	54.7	38.7	28.0	30.2
Rented House	79.6	82.2	81.8	77.8	41.3	61.3	68.7	69.8
Government plot/Staying in oth house(no rent) Œ	13.2	0.2	2.5	0.9	4.0	0.0	3.3	0.0
Base	**500**	**500**	**275**	**225**	**225**	**225**	**275**	**225**

Housing status (Continued) (percentage of adults by study sites)

	Bogra		Sirajganj		Madhabdi		Chitta-gong	All (Average)	
	End line	Base line	End line	Base line	End line	Base line	End line	End line	Base line
Own House	48.9	61.8	49.3	83.6	43.6	47.1	15.8	28.1	39.1
Rented House	34.2	37.8	5.8	3.1	55.6	52.0	82.0	61.6	58.9
Government plot/ Staying in others house, payment of rent not	16.9	0.4	44.9	13.3	0.9	0.9	2.3	10.3	1.9
Base	**225**	**225**	**225**	**225**	**225**	**225**	**400**	**2,350**	**1,850**

Money spent as house rent:

The largest segment of respondents (43.0%) spends house rent in the range of BDT.1000 to BDT.2000. This was similar to baseline survey. This range is followed by BDT.700 to BDT.1000. Very few spend higher amount also as house rent. Details can be seen from the table below.

Table- 10: Distribution of house rent paid by respondents (percentage of adults by study sites)

	Dhaka		Sylhet		Barisal		Khulna	
	End line	Base line	End line	Base line	End line	Base line	End line	Base line
Below 500	2.3	0.0	4.0	6.9	26.9	37.7	13.8	56.7
TK. 501 t 700	3.5	6.1	6.7	28.6	30.1	15.9	23.3	28.0
TK. 701 t 1000	11.8	16.1	17.8	28.6	25.8	26.1	36.0	8.3
TK. 1001 t 2000	46.0	54.5	56.0	30.3	17.2	20.3	15.9	5.1
TK. 2001 t 3000	27.4	12.4	13.8	3.4	0.0	0.0	7.4	1.3
TK. 3001 t 4000	7.5	3.2	0.9	0.6	0.0	0.0	1.6	0.0
TK. 4001 t 5000	1.0	3.4	0.9	0.0	0.0	0.0	0.5	0.6
TK. 5001 t 7000	0.5	3.4	0.0	0.6	0.0	0.0	0.0	0.0
TK. 7001 t 10000	0.0	1.0	0.0	1.1	0.0	0.0	1.6	0.0
Base-all respondents	**398**	**411**	**225**	**175**	**93**	**138**	**189**	**157**

Distribution of house rent paid by respondents (Continued) (percentage of adults by study sites)

	Bogra		Sirajgonj		Madhabdi		Chitta-gong	All (Average)	
	End line	Base line	End line	Base line	End line	Base line	End line	End line	Base line
Below 500	19.5	42.4	38.5	71.4	0.8	36.8	0.3	6.3	21.7
TK. 501 t 700	31.2	18.8	7.7	0.0	9.6	39.3	1.5	9.9	18.6
TK. 701 t 1000	27.3	11.8	0.0	28.6	30.4	10.3	11.3	19.0	17.3
TK. 1001 t 2000	18.2	22.4	30.8	0.0	45.6	10.3	58.8	43.0	31.6
TK. 2001 t 3000	3.9	2.4	23.1	0.0	12.8	1.7	17.1	16.0	5.8
TK. 3001 t 4000	0.0	2.4	0.0	0.0	0.0	1.7	5.2	3.6	1.7
TK. 4001 t 5000	0.0	0.0	0.0	0.0	0.8	0.0	4.3	1.5	1.4
TK. 5001 t 7000	0.0	0.0	0.0	0.0	0.0	0.0	1.5	0.5	1.4
TK. 7001 t 10000	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.6
Base-all respondents	**77**	**85**	**13**	**7**	**125**	**117**	**328**	**1,448**	**1,090**

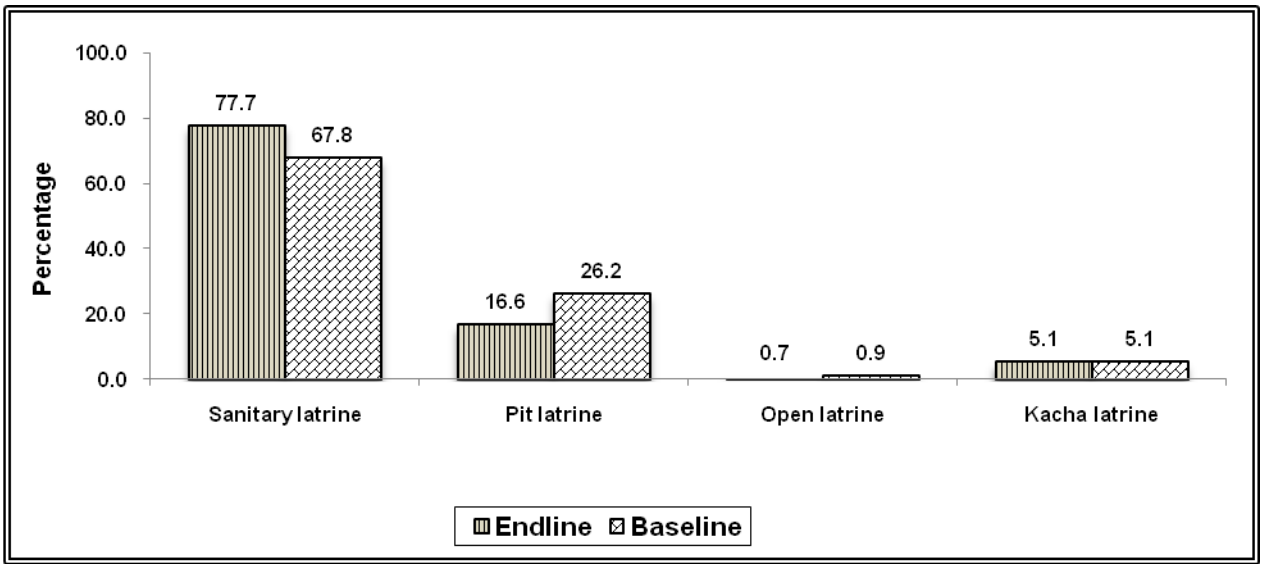
Drinking water/ bathing/ washing source:

In both surveys, it revealed that the majority of the respondents use tube well water for drinking. Use of supply water has increased 36.0% in end-line as compared to baseline figure of 30.0%. Majority of respondents also use tube well water for bathing. There were no noticeable differences on the washing practice of the respondents between the baseline and end-line survey. Both of the time, about 59.0% of the respondents used tube well water and 36.0% used supply water for washing.

Hygienic/ sanitary information:

Usage of hygienic/ sanitary latrine has increased from 67.8% in baseline to 77.7% in end-line survey. Usage of pit latrines has decreased from 26.2% in baseline to 16.6% in end-line. The practice of using Kacha latrine and/or open latrine has remained same from the baseline to end-line results (5.1% and 5.1%).

Figure- 1: Types of latrine used [Ref-Q3a]



Media exposure:

In the end-line survey, it revealed that, 3.0% of the respondents have radio and other do not have any radio. In the baseline survey, 10.0% respondents were found who had radio in their houses.

Electricity & gas:

In both surveys, availability of electricity has increased by four percentage points in the end-line survey to 63.0% from 59.0% at baseline. The use of gas in the house has slightly decreased to 39.0% in end-line survey from 41.0% of the baseline figure.

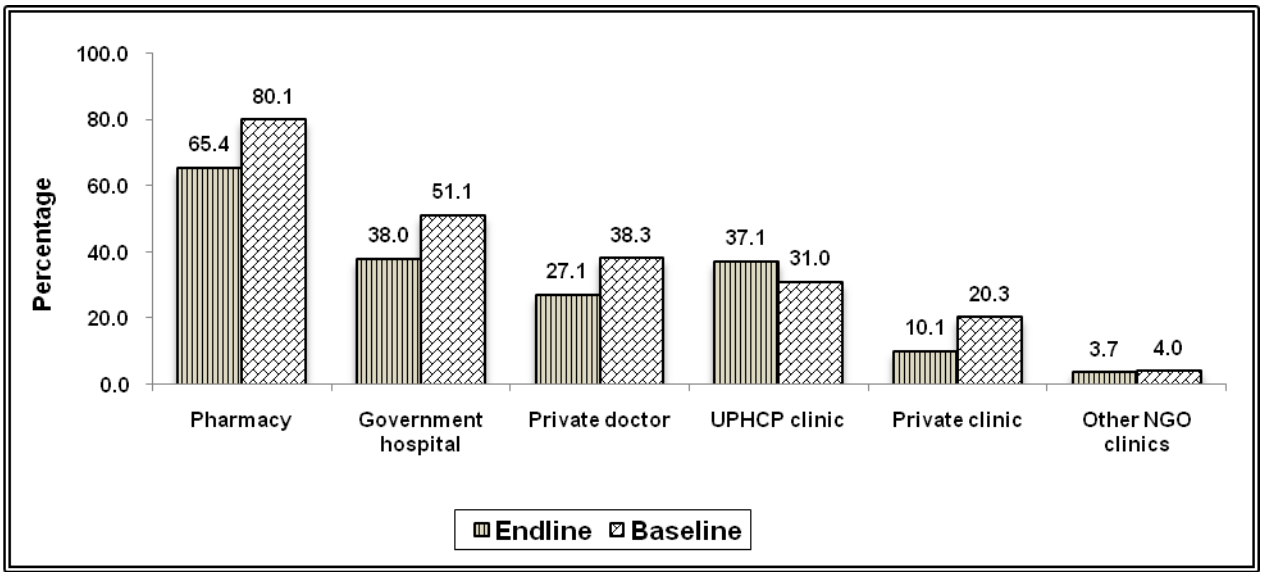
2.2 Healthcare Seeking Behaviour and Practices

Incidence of visiting places of healthcare services when falling sick:

The study revealed that majority of the respondents (65.0%) still visit pharmacy when they fall sick. This is followed by Government hospital (38.0%), UPHCP-II clinic (37.0%) and Private Doctor (27.0%). Center wise pattern is similar except in Madhabdi where people seem to visit Private Doctor (64.4%) more than Pharmacy (63.1%).

It can be seen from the graph below that seeking treatment from UPHCP-II clinics has gone up from baseline (31.0%) to end-line (37.0%) i.e. by 6.0% points, which has declined in all other cases.

Figure- 2: Incidence of visiting places of healthcare services when falling sick [Q5a]

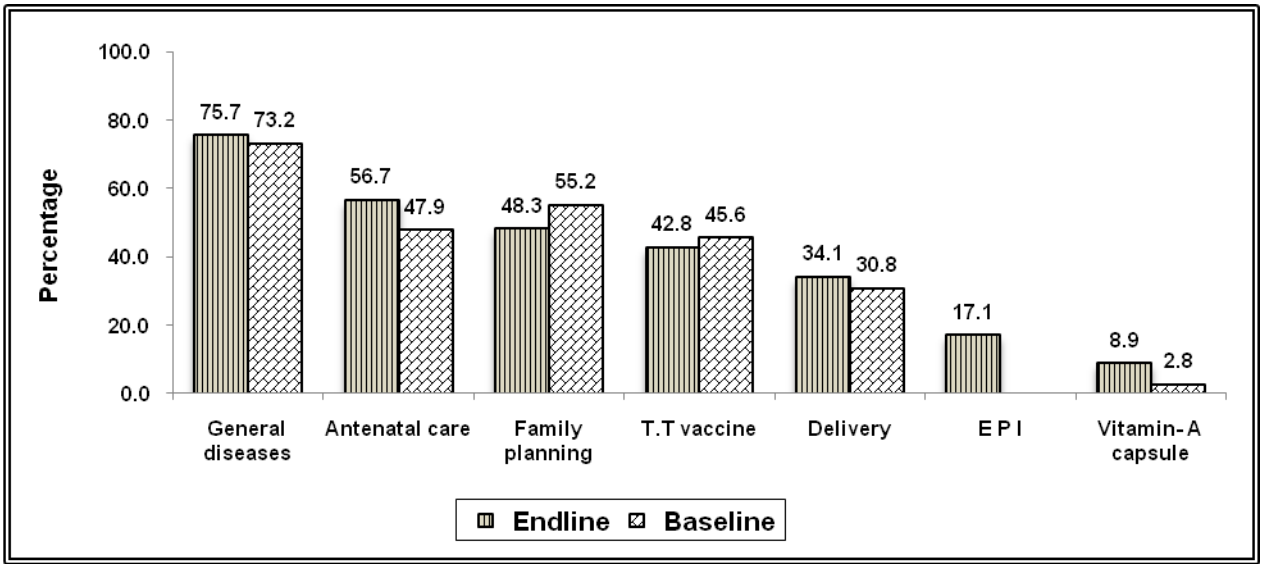


2.3 Use of UPHCP-II Services

Services for which adults visit UPHCP-II clinics:

Most of the respondents visit UPHCP-II o] v] • (} Œ š Œ š u v š } (Z ' v Œ o] • • • ~ Antenatal care (57.0%), Family Planning (48.0%), T.T vaccine (43.0%) and Delivery (34.0%). As compared to female (46.0%), very few male respondents (10.0%) visit UPHCP-II clinics for taking treatment and they mostly take treatment for general diseases (91.0%).

Figure- 3: Services for which adults visit UPHCP-II clinics [Q5b]



Pattern is similar in end-line and baseline surveys. However, it can be noticed from the above graph that visiting UPHCP-II o] v] • (} Œ ^ v š v š o Œ _ v ^ o] À Œ Ç _ Z À P } v µ ‰ respectively from baseline to end- o] v Á Z Œ • • l] v P • Œ À] } µ š ^ & u] o Ç ‰ o v decreased by 7.0%.

Incidence of visiting UPHCP-II Clinic on last occasion to receive healthcare service and frequency of visit in last 6 months:

It is noticed that majority respondents visited UPHCP-II clinics between last 1 and 5 months in last occasion. This pattern is similar across centers and genders also.

In last six months most of the respondents visited UPHCP-II centers between 1 to 3 times. Average number of visit has increased from baseline (2 times) to end-line (3 times).

Services for which last visit were made to UPHCP-II clinics:

About half of the adult respondents sought treatment of general diseases in their last visit to UPHCP-II clinics. Family Planning and Antenatal Care follow this. Center wise percentage distribution is similar except in Bogra where seeking family planning related service is very low.

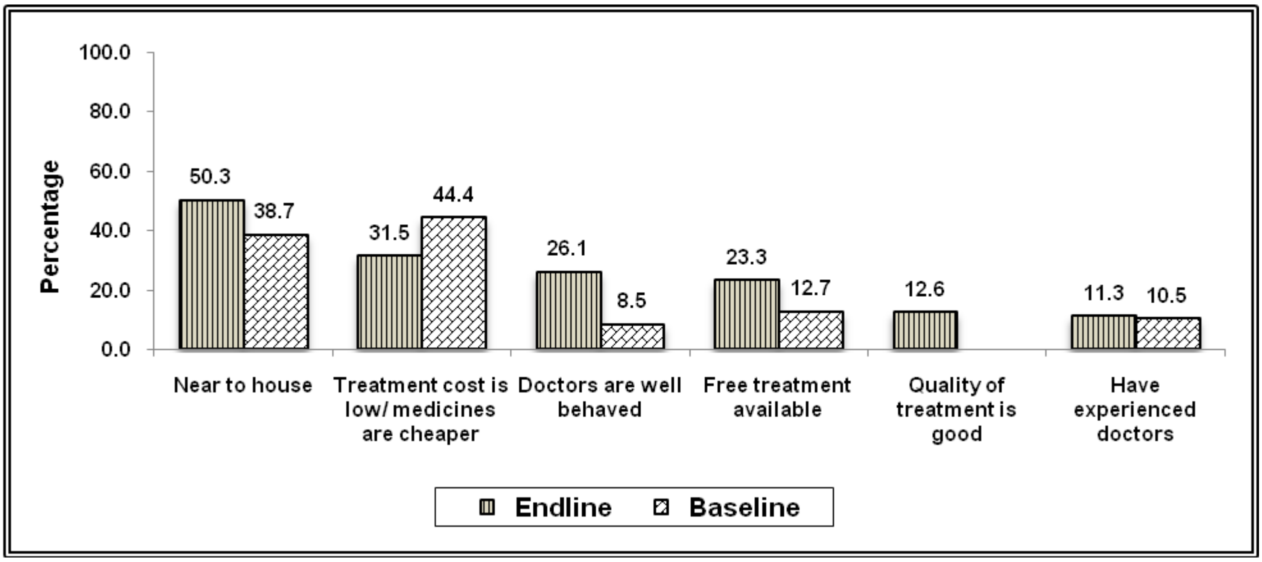
It revealed from both the studies (end-line and baseline) that respondents mostly took treatment for ^ ' v Œ o] • • •] v š Z] UPHCP-II clinics] A] compared to th • o] v U š l] v P ^ & W o v v] v P _ Œ o š • Œ À] baseline v o] v l] (Œ } U v š v _ š Œ o Œ • Œ À] increased.

Reasons for visiting UPHCP-II clinics for other than health care services:

Proximity of the clinics to house is a strong reason to visit UPHCP-II clinics (50.0%). Other reasons for taking treatment from UPHCP-II o]v] • Œ ^>}Á }•š ~ïîXì9•_U ^ } š}9Œ•_ Œv Á ^&Œ šŒ šu vš .0À•]_oX dZ]• î‰ šš Œv o}}l• •]u]o Œ u}vP vš Œ•X

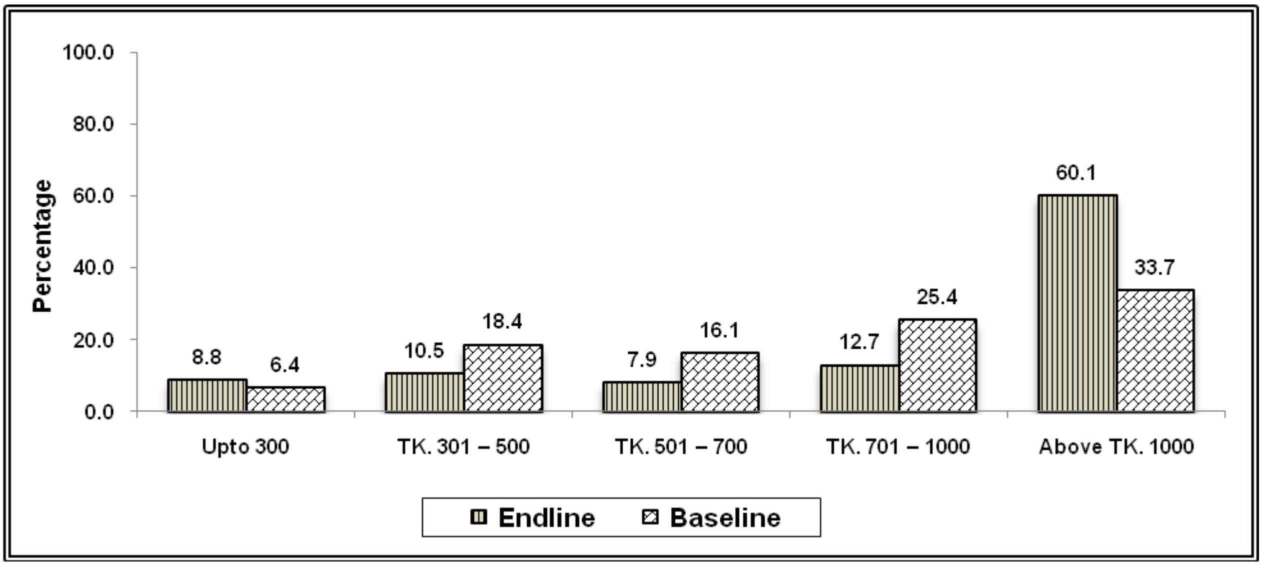
In ba• o]v Z>}Á }•š[Á • šZ š}‰ }v•] ŒUPHCP-II clinics while it was ~ñìïX9•_ {^Œ ÀŒ•]š]vP Z}µ• ~ñìïXì9•_ in the end-line X W}}Œ Œ •‰}v vš• }v•] Œ ^&Œ šŒ šu vš factor more in end-line (27.2%) as compared to baseline figure of 11.2%. In end-line, about 13.0% Œ •‰}v vš• À oµ š ^Yµ o]šÇ }(šŒ šu vš]•UPHCP-II clinics which was µoµ• not found during baseline.

Figure- 4: Reasons for visiting UPHCP-II clinics for health care services: anything else [Q5e]



2.4 Money Spent for Treatment

Figure- 5: Money spent on treatment for the last 6 months (percentage of adults by study sites) (D.7)



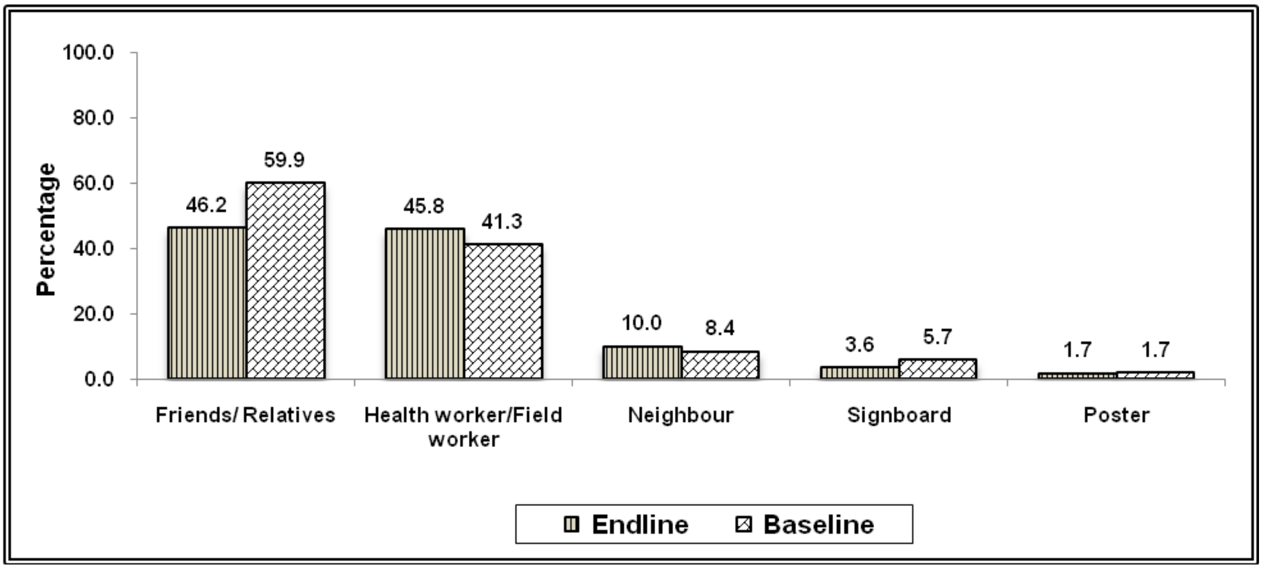
In last six months (from end-line survey) amount of money spent for treatment has gone up and it is almost double as compared to baseline figures, in all amount ranges. However, the noticeable difference is this that now majority respondents needed to spend more than BDT.1000 for treatment although only a small section wants to spend that much money. This means high cost of treatment is against their willing choice (Figure- 5).

2.5 Motivation to Visit UPHCP-II Clinics

Motivating factors to visit UPHCP-II clinics:

Z&Œ] v •lŒ o š]À • ~ðòXî9•[Œ šZ u]v u}šit UPHCP-II clinics, followed Œ •‰ Ç Z, o šZ Á}ŒlŒ ~ðñXô9•[X}v/vvš•Œ]}v o]U Œì XZî,9 Z as main motivator and]v Z]šš P}vP ôïXï9 Œ •‰}v vš• Œ }Pv]Ì Z&Œ] v end-line, o Zš]Ào š Z • Á}ŒlŒ[Œs growing important motivators for respondents to visit clinics as compared to baseline when friend/relatives had that place.

Figure- 6: Motivating factors to visit UPHCP-II clinics [Q5h]



2.6 Quality of Services at UPHCP-II Clinics

Perception of quality of services provided by UPHCP-II clinics:

Among those respondents who visit UPHCP-II clinics, more than half (55.1%) rate their service quality as Z'}} [X šÁ v vš Œ• v P v Œ•U š Zpopulation, also majority respondents }}Œ Œš • ŒÀ] }(šZ o]v] • • ZP}} [X

Both in end-line and baseline husbands had rated the services of UPHCP-II clinics lower than female respondents.

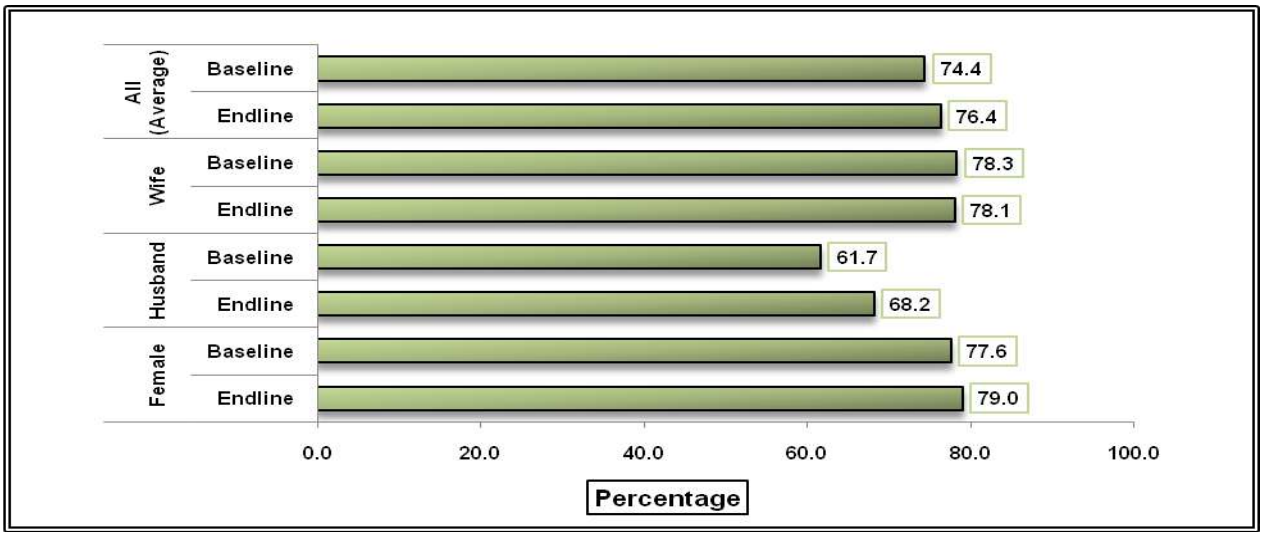
Table 11: Perception of quality of services provided by UPHCP-II clinics [Q7] Figure in %

	Female		Husband		Wife		All (Average)	
	End-line	Baseline	End-line	Baseline	End-line	Baseline	End-line	Baseline
Very Bad	0.6	0.7	1.3	2.4	0.9	0.6	0.8	1.0
Bad	5.1	3.7	6.6	4.9	6.4	2.6	5.7	3.6
Fair	12.9	4.7	16.8	16.7	14.0	5.1	14.1	7.4
Good	54.6	59.8	55.8	50.9	55.3	56.1	55.1	56.9
Very Good	17.2	16.3	5.3	4.2	13.2	19.7	13.5	14.6
Do not Know/ Cannot Say	9.7	14.9	14.2	20.9	10.3	16.0	10.9	16.4
Average	**3.9**	**4.0**	**3.7**	**3.6**	**3.8**	**4.1**	**3.8**	**4.0**
Base	**886**	**706**	**380**	**287**	**456**	**351**	**1,722**	**1,344**

2.7 Perception about Service Providers at UPHCP-II Clinics [Who Visit +Who are Aware]

Feeling about the service providers at UPHCP-II clinics:

Figure- 7: Feeling about the services providers at UPHCP-II clinics [Q9a]



The end-line data shows that most of the respondents, who visited UPHCP-II clinics as well as who knew that clinic exists in their locality, (76.0%) have rated service providers of UPHCP- / / o]v] • • ZP}} [v

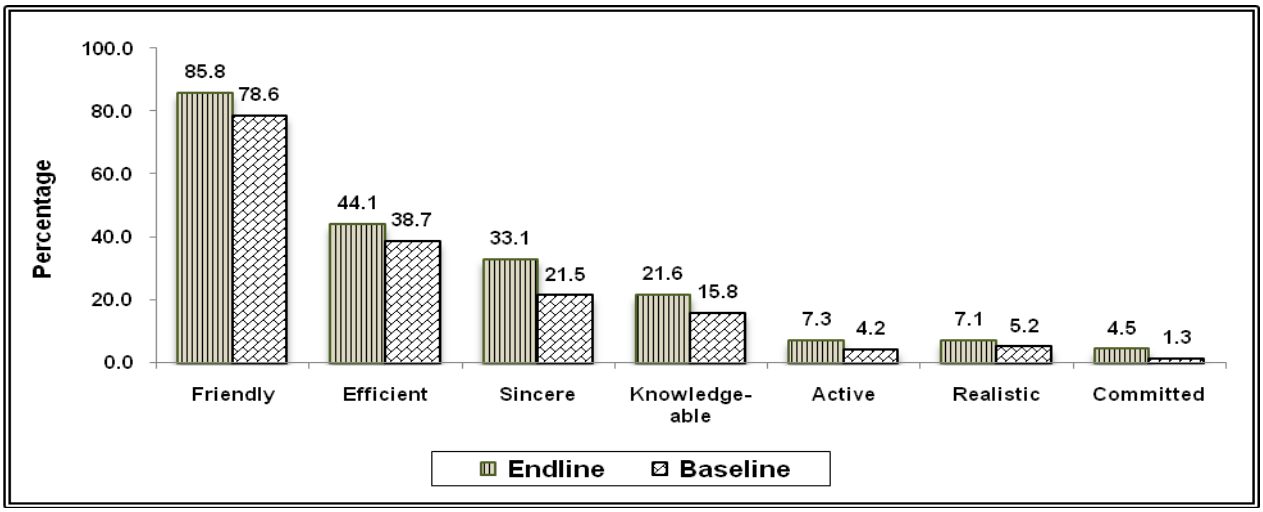
has increased a little in end-line as compared to baseline. Similar trend exists across centers and male-female respondents. In poor population also more than three-fourth respondents rated the service ‰ Œ } À] Œ • Œ Z P } } [v š Z] • end-line and baseline studies. Œ] v } š Z

Z • } v • (} Œ š Z] v l] v P š Z o] v] • [• Œ À] ‰ Œ } À] Œ • • P } } W

Most of š Z Œ • ‰ } v v š • ~ ô ñ X ô 9 • (} µ v š Z • Œ À] ‰ Œ } À] Œ • Z (Œ]
~ ð ð X ì 9 • _ v Z ^] v Œ ~ ï ï X ì 9 • [X d Z •] u] o Œ ‰ š š Œ v Æ] • š • š Á v

It can be seen from the graph that proportions of all good qualities of service providers have increased from baseline to end-line and in almost all directions.

Figure- 8 W Z • } v • (} Œ š Z] v l] v P š Z o] v] • [• Œ À] • P } } € Y õ •



2.8 Discussions about UPHCP-II Health Services

Sharing and discussions made about healthcare services of UPHCP-II clinics:

The end-line data shows that more than half of adult respondents shared their experiences about the healthcare services of UPHCP-II clinics with people around them.

Most of the respondents discussed health care services of UPHCP-II with neighbors. The female respondents seldom show any interest to discuss this issue with others except neighbor. An exception can be noticed within husbands who •] š Z š š Z Ç] • µ • • š Z] •] • • µ Á] š Z (Œ] v • š Z as first choice of majority among them.

2.9 Non-user of UPHCP-II Services

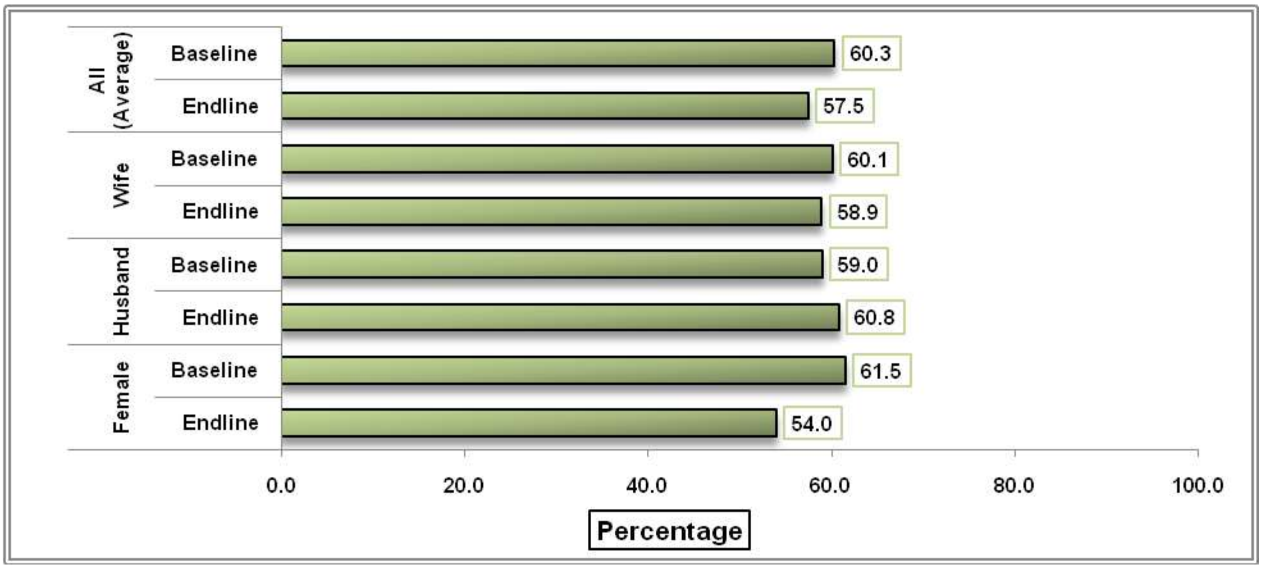
Awareness about existence of any UPHCP-II o] v]] v Œ • ‰ } v v š [• o } o] š Ç **users:** € Á Œ µ š

A portion of the adult respondents who do not visit UPHCP-II clinics are aware about existence of the o] v] •] v š Z] Œ o } o] š Ç v o • } š Z } • Á Z } Œ Non-user of UPHCP-II Á Œ À] • Œ] v š Z š Z study. Study revealed that who did not visit UPHCP-II clinic among them more than half of the respondents (57.5%) are aware about the existence of UPHCP-II clinic in their locality and 28.0% respondents are totally unaware regarding such existence. Awareness about this issue is high in Sirajganj

(84.0%), Barisal (80.0%), and Khulna (77.3%) and comparatively low in Chittagong (38.0%), Dhaka (47.0%) and Sylhet (43.0%). In Sylhet, 55.0% respondents were totally unaware about the existence of UPHCP-II clinics in their locality.

• Z • v • v (Œ}u šZ PŒ ‰ZU Œ •‰}v vš[• Á Œ v •• }v šZ]• points from baseline (60.0%) to end-line (56.0%).

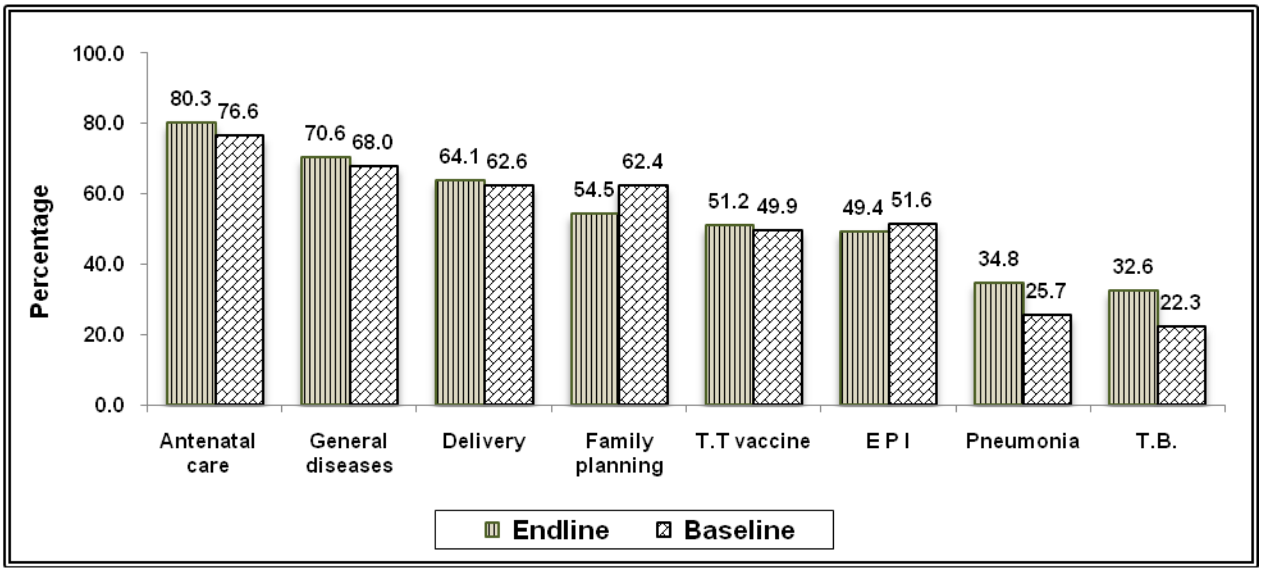
Figure- 9: Awareness about existence of any UPHCP-II cl] v]] v Œ •‰}v v š[re but non-users] € [Q6a]



Availability of services in UPHCP-II clinics:

Respondents who are aware but non-users of UPHCP-II clinics, as well as those who visited the UPHCP-II clinics, are well aware of the services offered by the clinics. During the study, they could tell about the u i}Œ • ŒÀ] • ‰Œ}À] Ç šZ o]v] •X dZ • Œ U ^ vš~ ó í X ì9•_ Œ ^ o]À ŒÇ ~ò ð X ì 9•_U ^& u]oÇ Wo vv]vP ~ñ ñ X ì 9•_ v ^d X d À]v ~ among centers and with regard to service category.

Figure- 10: Availability of services in UPHCP-II clinics [aware but non-user+ users= [Q5a] & [Q6b]

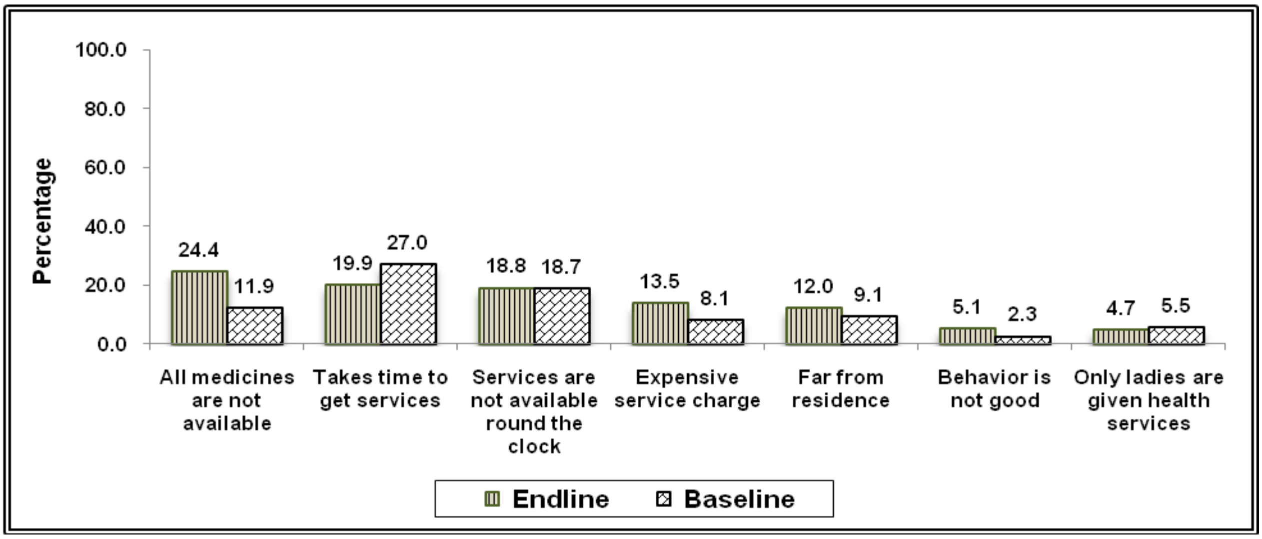


Noticeable changes between baseline and end-line awareness response figures can be seen in service š P}Œ] • o]l ^& u]o-Ç ‰ oend-line 55.0%, baseline = òîXì9•_U ^W v]u v] end-line 35.0%, baseline = îòXì9•_ v ^dµ Œ µ o }Ç end-line 33.0%, baseline = îîXì9•_X

Reasons for not visiting UPHCP-II clinics to receive services:

The respondents who knew existence of UPHCP-II clinics in their locality but did not visit same were asked šZ Œ •}v•X dZ •µŒÀ Ç Œ •µoš• Œ À o šZ š }À Œ oo ~îðXì9•[ ]• šZ not taking services from UPHCP-II o]v] • o}• oÇ (}oo}Á Ç Zd l • š]u š} P š • v}š o Œ •}v• Œ ^^ ŒÀ] • Œ v}š À]o o Œ }µv clock charge o} l ~ ~íðXì9•_U v ^& Œ (Œ}u Œ •] v ~íîXì9•_X • v • vU]u‰] Madhabdi, 58.0 9 Œ •‰}v vš • Œ] • Z[oo u]]v• Œ v}š À]o o [UPHCP-II clinics. In Dhaka 32.0% respon vš• • Œ] Zd l • š]u š} P š • ŒÀ] •[ ]• not visiting UPHCP-II clinics.

Figure- 11: Reasons for not visiting UPHCP-II clinics to receive services [Q6c]



/v • o]v U Œ •‰}v vš• }v•] Œ u}•š ^dó Xì9 š]u •šš ZP uš]v ŒÀ] •}v visiting UPHCP-II o]v] •X dZ ‰Œ}‰}Œš]}v }(šZ]•]••µ Z • o]v š} îìX u]]v • Œ v}š À]o o ~îðXì9•_ • šZ UPHCP-II clinics in end-line v}š À] ^ Æ ‰ v•]À service charge (end- o]v A íðXì9U • o]v A ðXì9•_ v ^(Œ }u Œ baseline A õXì9•_ Œ v}šZ Œ šÁ} v}š Á}Œš ZÇ UPHCP-II clinics whose proportion have increased in end-line from baseline.

2.10 Intention to Use UPHCP-II Health Services

Intension of visiting UPHCP-II clinics in future to receive services [Who are aware but do not visit + who visit=Q5a]:

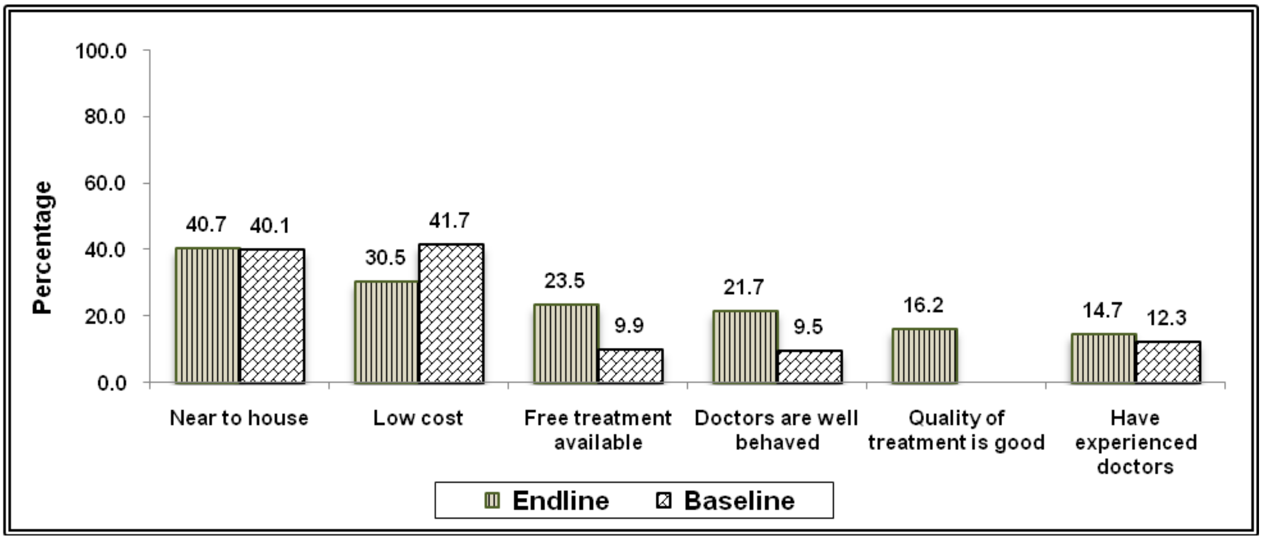
A larger part of the respondents have expressed their intention to visit UPHCP-II clinics in future. This intension is lower within husbands compared to female respondents. The pattern of showing interest to visit UPHCP-II clinics is similar among centers.

Reasons for visiting UPHCP-II clinics in future to receive services [Q5a]:

The reason that drives most of the respondents to go to UPHCP-II o] v]] v (µ š µ Œ]• ^E Œ (40.7 9•_X d Z]•]• (} o o } Á Ç ^>}Á }•š ~ï í X ì 9•_U ^&Œ šŒ šu vš À Z À ~î î X ì 9• _X d Z]• ‰ šš Œv • u• š} pt Chittagong where respondents Œ• } v •] Œ ^>}Á }•š ~ï ð X ì 9• prime factor. Out of the poor population majority (58.0%) of them will visit UPHCP-II clinics for two main } v •] Œ š] } v ~ Z >}Á = }Z & Œ î ô X ì 9 š u vš À] o o

In baseline ^>}Á }•š ~ð î X ì 9•_ Á • š Z š } ‰ UPHCP-II clinics which is changed by ^E Œ š } Z}µ• in end-line ~ð í X ì 9• _W } Œ } ‰ } Œ š] } v } (^ } š}Œ• Œ Á o o Z À _ in end-line from baseline Á Z Œ • ^&Œ šŒ o š u vš] v À Œ • • Ç í î X ì 9 (Œ } u line X W}}Œ Œ •‰}v vš• } v •] Œ ^&Œ šŒ šu vš À] o in end-line • u (30.0%) as compared to baseline (11.0%). In end-line U }µš í ï X ì 9 Œ •‰}v vš• À o µ š treatment]• P}} _ • v] u‰}Œš vš Œ UPHCP-II clinics which was not found during base line.

Figure- 12: Reasons for intending to visit UPHCP-II clinics to receive services [Q8b]



Resons for not visiting UPHCP-II clinics in future to receive services [Q.8a] :

The few main reasons for not visiting the UPHCP-II clinics in futur Œ Z d Œ š u vš À, Œ Ç Z D]] v Œ v } š o Á Ç • À] o o Free medicine not available [X K š Z Œ Œ • } v • are not Z } š well behaved [v Have to wait for long time [It is noticed that among centers, these are considered as the main factors but percentages vary.

As compared to baseline, in end-line ‰ Œ } ‰ } Œ š] } v } (š Z • (š } Œ • Z •] v Œ • Z d Z D]] v Œ v } š] o Á o Ç [• v À Z & Œ u]] v v } š À] o o [X

2.11 Suggesting Others to Use UPHCP-II Services

Suggesting others to receive services from UPHCP-II clinics:

The end-line data shows that overall two-fifth of the respondents have suggested others to receive service from UPHCP-II clinics. The response pattern seems similar between centers and genders. People whom š Z o] v] µ• Œ• • µ P P •š š} À] •] š š Z Œ Œ u } • š o Ç Z E] P Z } Œ • [

2.12 Motivating Factors to Visit UPHCP-II Clinics

The respondents think that the following issues can motivate people in the community to visit to UPHCP-II clinic. In order of importance these are:

- Low treatment cost
- High quality health service
- Healthcare is within reach
- Provide free treatment
- Medicine given free of cost
- Health services are given by experienced doctors

The above stated five issues are similar between centers and genders but proportions of response pattern are different.

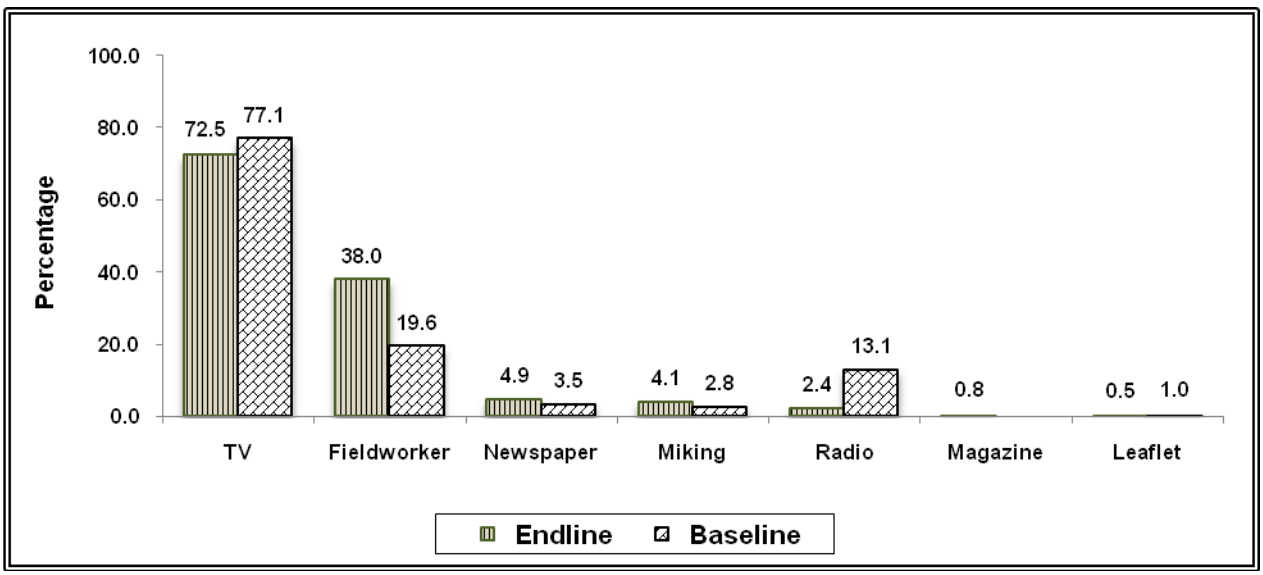
2.13 Media Preference

Preferred media (print, radio, TV, others) through which respondnets would like to receive these messages:

The majority of the respondents (72.5 9 • Z À ‰ Œ (Œ Œ Z d s [(} Œ Œ] (Figure u } š] À 1 ï • X d Z ‰ š š Œ v] • •] u] o Œ š Á v v š Œ • v P v X Œ wisal, Æ ‰ š whoppi v P U õ ì X ì 9 Œ • ‰ } v v š • Z À • š š Z &] o Á } Œ l Œ [• ‰ Œ (Œ Œ ‰ Œ } ‰ } Œ š] } v ~ ñ ò X ì 9 • } (Œ • ‰ } v v š • Z • Æ ‰ Œ • • Z &] o Á } Œ l Œ [first choice.

d Z ‰ Œ (Œ v } (Z d s [4.0 ‰ points in end-line from baseline (77.0%). On the other hand, ‰ Œ (Œ v (} Œ Z &] o Á } Œ l Œ [Z •] v Œ • end-line. This change can be observed in all centers and gender groups. Specially in Dhaka, where none of the respondents evaluated ^ &] o Á } Œ l Œ _ • ‰ Œ (Œ Œ u] š } Œ] À line u 34.0% respondents Z • ‰ Œ (Œ Œ ^ &] o Á } Œ l Œ _ š } Œ] À u • • P • X

Figure- 13: Preferred media(print, radio, TV, others) through which respomdnets would to receive these messages[Q10d]



Whether watch TV:

It is found in end-line that most of the respondents watch TV. The pattern of TV viewership is similar among centers and genders.

Name of preferred TV channel and preferred watching time:

The following channels have emerged as the preferred channel in end-line. In order of popularity these are:

- Star Jalsa
- ATN Bangla
- Channel-I
- BTV
- Star plus
- Zee Bangla
- nTV

As revealed from the study, the most popular time for watching TV is 8- 10 pm, which is followed by 10 pm - 11 pm and 7 pm - 8 pm.

2.14 Pregnancy-Related Knowledge and Practices

Number of times a pregnant woman should visit a health center for health check-up:

The end-line data shows that majority of the respondents said that on an average pregnant women should visit health center 5 times. The trend is similar between centers and genders

Incidence of anyone becoming pregnant in family during last five years:

In the end-line survey, more than half of the respondents had reported that someone of their family became pregnant during last five years.

Kind of care that a pregnant woman needs and Care received by a woman in the family who became pregnant during last 5 years:

Table- 12: Cares those pregnant women need [Q.13a, Q13b and Q13c] Figure in %

	Spontaneous		Prompted		Total Awareness		Antenatal care received	
	Q13a		Q13 b				Q13c	
	End line	Base line	End line	Base line	End line	Base line	End line	Base line
Regular Physical checkup	45.4	29.7	53.1	69.1	98.4	98.8	46.0	46.1
Regular intake of balanced diet	86.0	78.6	13.3	21.1	99.4	99.7	52.9	58.4
Take TT vaccine in proper time	19.4	23.8	79.0	73.8	98.4	97.6	45.9	56.1
Take sufficient rest	59.3	57.6	39.4	40.0	98.7	97.6	48.4	51.9
Avoid heavy work	60.9	56.7	36.9	42.3	97.8	99.0	45.1	51.6
Others	3.1	0.9	0.0	0.1	3.2	1.0	0.4	0.1
Unaware	2.1	3.2	5.9	0.4	8.0	3.6	1.1	0.2

Base All Respondents (Adult)

The end-line survey data reveals that respondents are totally aware regarding different kind of antenatal cares that are necessary by pregnant women. No noticeable difference is seen between end-line and • o] v • µ Œ À Ç • X & } Œ Z v š v š o Œ Œ] À [U š Z Œ • ‰ } v • ‰ from baseline to end-line.

Complicacy during delivery [Q.13d] Prompted:

Z • ‰ } v v š [• Á Œ t µ r e g n a n c y p e r i o d complications have decreased for all cases as revealed during end-line survey as compared to baseline, which can be seen from the table below.

Table- 13: Complicacy during delivery [Q.13d] Prompted [Q.13e]

Figure in %

	Spontaneous		Prompted		Total Awareness	
	Q13d		Q13e			
	End line	Base line	End line	Base line	End line	Base line
Excessive Vaginal Bleeding	44.9	47.2	43.0	44.7	87.9	91.9
Severe headache/ blurred vision	32.0	30.4	55.3	58.7	87.3	89.1
Sevier fevers	29.3	29.6	59.7	53.8	89.0	83.4
Convulsion	43.4	37.2	46.5	56.0	89.9	93.2
Longer duration of pangs of childbirth	31.2	34.4	54.5	59.4	85.7	93.8
Come out other limbs rather than head	16.2	15.0	64.6	74.3	80.8	89.3
Others	15.6	3.9	0.8	0.6	16.4	4.5
Unaware	10.0	11.4	2.6	0.7	12.6	12.1

Postnatal cares required for pregnant women after delivery:

Most of the respondents have described requirement of postnatal cares. In order of importance these are:

- Z d l v µ š Œ] š] } µ • (} } [
- Z d l Œ • š Œ P µ o Œ o Ç
- Z À }] Z À Ç Á } Œ l

Complication likely to arise within 42 days of delivery:

The end-line data reveals that the respondents have stated mostly following complications, which may arise within 42 days of delivery X / v } Œ Œ } (v µ u Œ } (Œ • ‰ } v v š • [À] Á • š Z •

- Excessive Vaginal Bleeding
- Convulsion
- Body fluid increases
- Severe headache
- Severe fevers
- Blurred vision

Same pattern can be seen among centers and genders.

2.15 Nutrition-Related Knowledge and Practice

Number of times pregnant women have to take meal daily on an average:

More than one third of the respondents said that the pregnant woman should take meals 5 times in a day. Others said 4 times and 3 times also. o u } • š o o š Z Œ • ‰ } v v š • } v •] Œ Z P Œ v source of nutrition. The other stated nutritious foods consist of Z &] • Z l D [š M i l k P [P U f r u i t s Z [

This pattern is similar among centers and genders and between end-line and baseline also.

/ v] v } (Z À] v P v Ç Z] o o } Á ( ] À Ç Œ •] v Œ • ‰ } v v š [• (u] o

In end-line survey, more than half of the respondents said that they have child below 5 year of age in their family. The response pattern is similar between centers and genders.

Duration of breast-feeding š } Z] o Œ v] v Œ • ‰ } v v š [• (u] o Ç W

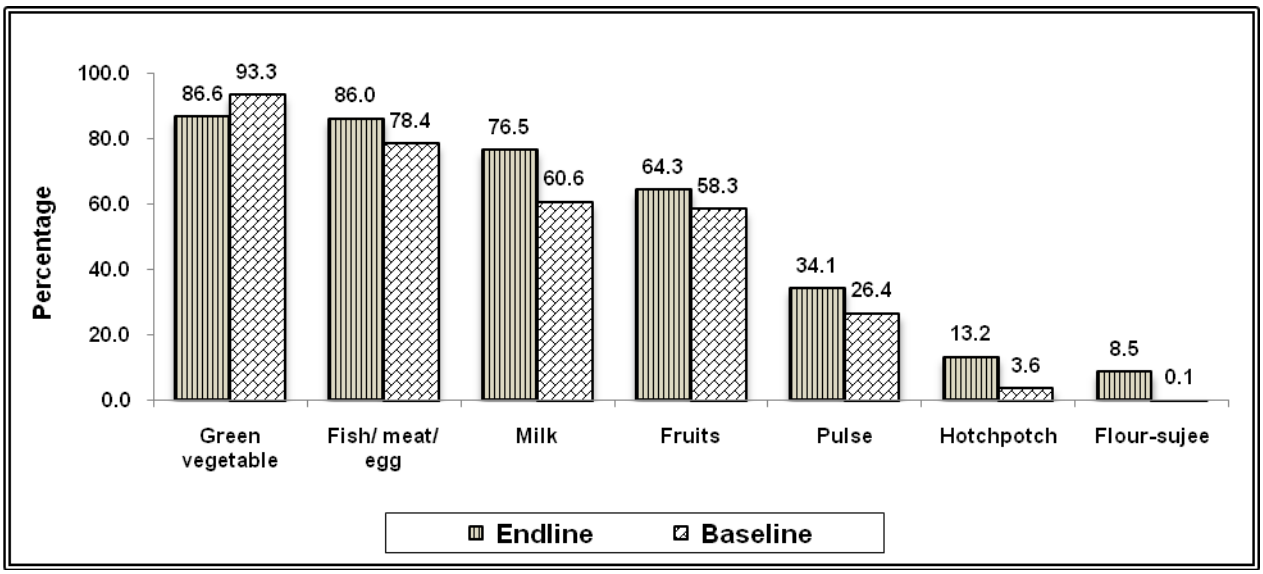
The survey data reveals that on average children need to be exclusively breast-fed up to 6 months as a larger part of the respondents have reported this. The pattern is similar among centers and genders and between end-line and baseline.

Nutritious food that are usually taken by the children of respondents family:

The end- o] v š • Z } Á • š Z š ô ó X ì 9 Œ • ‰ } v v š • Z À Œ ‰ } Œ š š Z š
À P š o [X K š Z Œ • š š h o u s e h o l d s u s u a l l y t a k e a r e š ^ &] • Z l u š l P P ~ ô ò X ì 9 • _
~ ó ó X ì 9 • _ U ^ & Œ µ] š ^ • W ~ ò µ ð • X ì 9 ð _ X ì 9 v • _ X š Á v v š Œ • v P v Œ • U š Z

• o] v š • Z } Á • š Z š õ ï X ì 9 Œ • ‰ } v v š • Œ ‰ } Œ š Z ' Œ v - l i n e À P š
it has decreased to 87.0%. Except this, proportions of all other cases have been increased from baseline to end-line.

Figure- 14: Nutritious food that are usually taken by the children of respondents family [Q18]



2.16 Immunization and EPI

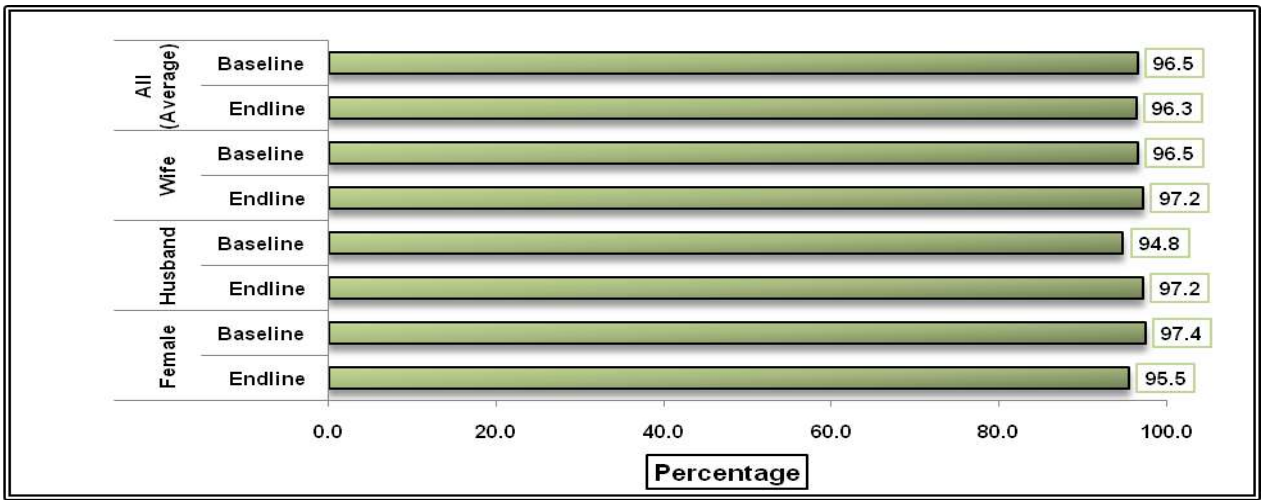
Giving extra food to 6 months old children along with breast milk:

Almost all of the respondents (90.0%) reported that children of their family crossing 6 months take other foods along with breast-feeding. The responses are similar between centers and genders about this issue.

Z] o Œ v } (Œ • ‰ } v v š • [(u] o Ç Z À] v P v À] v š W

Both in baseline and end-line, 96.0% respondents informed that children of their family were vaccinated. The response pattern is identical in end-line and baseline and also between centers and genders.

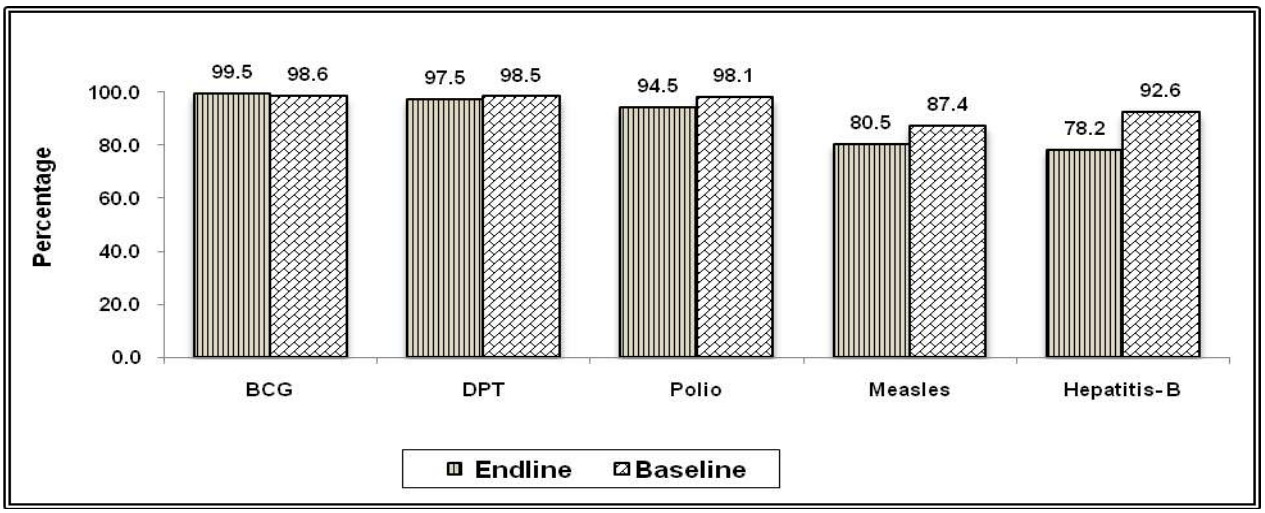
Figure- 15 W Z] o Œ v } (Œ • ‰ } v v š • [ccinated [Q19a] À] v P v À



Vaccines that were given to the children of respondents family:

It can be seen from graph below that proportion of BCG has increased by 2.0% points in end-line from baseline figures. Except this, proportions of different vaccines have decreased a little as compared to baseline and noticeable change took place in Hepatitis-B (by 14.0% points). The percentage distribution is almost similar among centers.

Figure- 16: Vaccines that were given to the children of respondents family [Q19b]

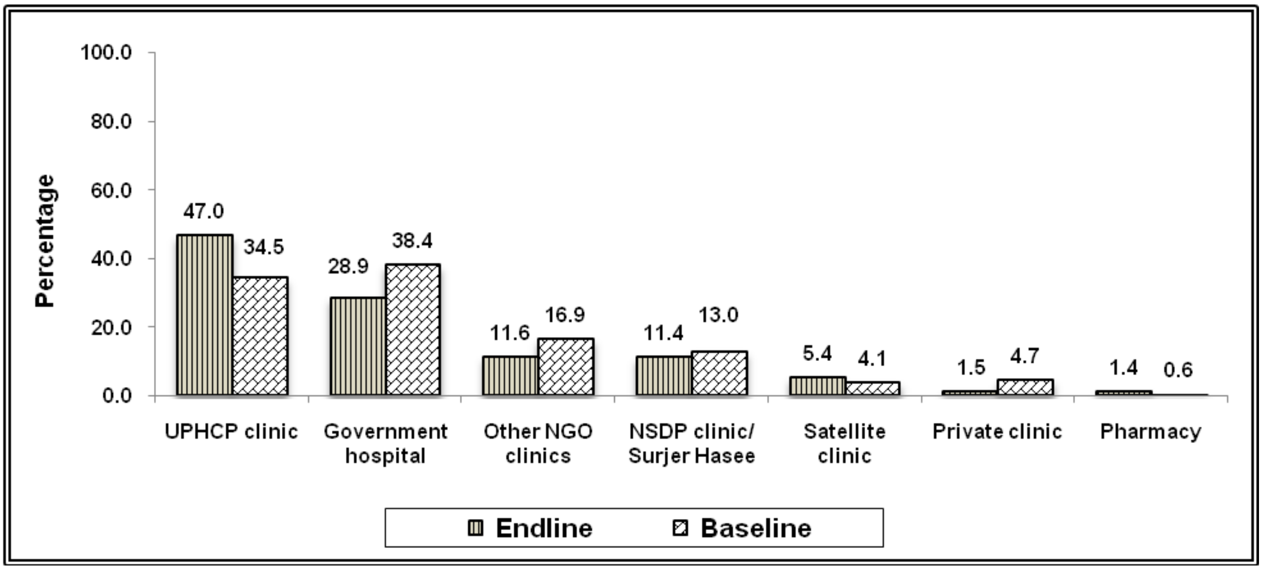


Place of vaccination of children of respondnets family:

It revealed during end-line survey that about half of the respondents (47.0%) have taken their children to UPHCP-II clinics for vaccination (Figure- 17). Other noteworthy places where respondents had taken their Z]o Œ v Œ ^'}À Œv(29.0%)• ‚ }K‰ Zš Œ E'K o]v] • ~íîXì9•_ v E^ W
Among the centers less numbers of respondents visited UPHCP-II clinics for vaccination were in Bogra (25.4%) and in Sirajganj (20.4%). On the other hand, in Khulna, 71.0% respondents have visited UPHCP-II clinics for vaccination, which is highest among centers.

As compared to baseline, visiting UPHCP-II clinics for vaccination have increased by 13.0% in end-line and on the other hand, P}]vP š} ^'}À Œvu vš Z}•‰]š o_ Z • Œ • Ç õXì9 ‰}

Figure- 17: Vaccines that were given to the children of respondents family [Q19c]



Z •}v• (}Œ Z]o Œ v• }(Œ •‰}v v š•[(u]oÇ v}š Z À]vP v À]v

It is revealed from the end-line šZ š Z& Œ }(•] ((š[ ]• šZ u]v Œ •}v (}Œ v (}Œ]uuµv]Ì š]}vX KšZ Œ v}š Á}ŒšZÇ (š}Œ• Œ Z& u]oÇ Œ •šŒ] pattern is similar among centers.

Incidence of taking TT vaccine:

The end-line data shows that a highest majority of female respondents have taken TT vaccine. The pattern is similar between centers and genders.

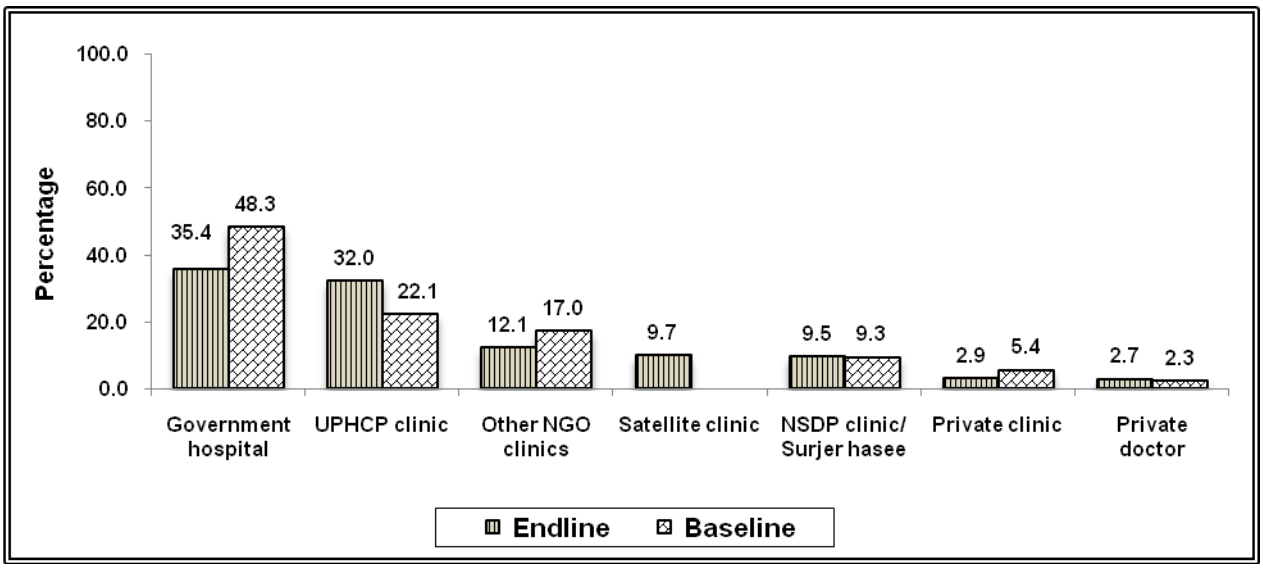
Place of TT vaccination:

The end-line shows that 35.0% respondents have taken TT À]v š]}v (Œ}u Z'}À Œvu vš Z}•%
Z'}À Œvu vš Z}•‰]š o[v šZ]•]• from baseline (figure- 18). The Œ •‰}v v š• Z À o•} š l v UPHCP-II Œ}u Z'}À Œvu vš Z}• [U ZKšZ Œ E'K o Z^ š oo]š [~íìXì9•U ZE9•[/š]• v}š] šZ š ‰Œ}‰}Œš]}v }(Œ •% providers has varied among centers.

It can be seen from the graph below that Government hospital (48.0%) was the first choice of the respondents for taking TT vaccine in baseline but in end-line, taking TT vaccine from Government Hospital

Z • Œ • }v•] Œ oÇX Kv šZ }šZ Œ ZUPHCP-šl]ov]P] d[dZÀ•]ŸvŒ(Œ}
10.0% points from baseline to end-line.

Figure- 18: Place of TT vaccination [Q20b]



Reasons for not taking TT vaccine:

The survey data shows that more than one-third of the respondents did not take TT vaccine because of ignorance. Other reasons of not taking TT vaccine are fear of side ((š[Zv& u]oÇ Œ •šŒ] š]}v[reasons for not taking TT vaccine. Center wise pattern is similar except Khulna and Barisal where Œ •‰}v vš• Z À }v•] Œ Z& Œ }(•] ((š[•u]v Œ •}vX

2.17 Child Diarrhoea

Meaures needed to be taken immediately if any child suffers from diarrhoea:

&Œ}u šZ š o o}ÁU]š]• o Œ šZ š ZE š}([KZ^]• šZ }v
almost every respondent both in baseline and in end-line.

Table- 14: Meaures needed to be taken immediately if any child suffers from diarrhoea [Q21a]

	End-line (%)	Baseline (%)
Need to feed ORS	96.4	98.6
Necessary to take Thana Health Complex	2.3	0.8
Necessary to take District Sadar Hospital	0.6	0.5
Necessary to take health care center	1.7	0.2
Necessary to take Sabuj Chaata Clinic	0.1	0.1
Necessary to take Surjer Hashi Clinic	0.0	0.1
Necessary to take UPHCP-II Clinic	0.6	0.1
Medicine from Pharmacy	0.9	0.1
To go to doctor doing private practice	0.2	0.1
Medical college hospital	0.0	0.1
Cannot say	0.2	0.0
Base : All Respondents	**2,350**	**1,850**

Foods needed to be given during diarrhoea:

Most of the respondents have informed that ORS should be given if any child suffers from diarrhoea. Other foods needed to given during diarrhea are Z v } Œ u o Z oUš ZZÇ Œ{ } } • šŠ ([U Z Z µ • l Œ Z } } v µ š Á š Sa Œ [µ pattern was seen between centers and genders.

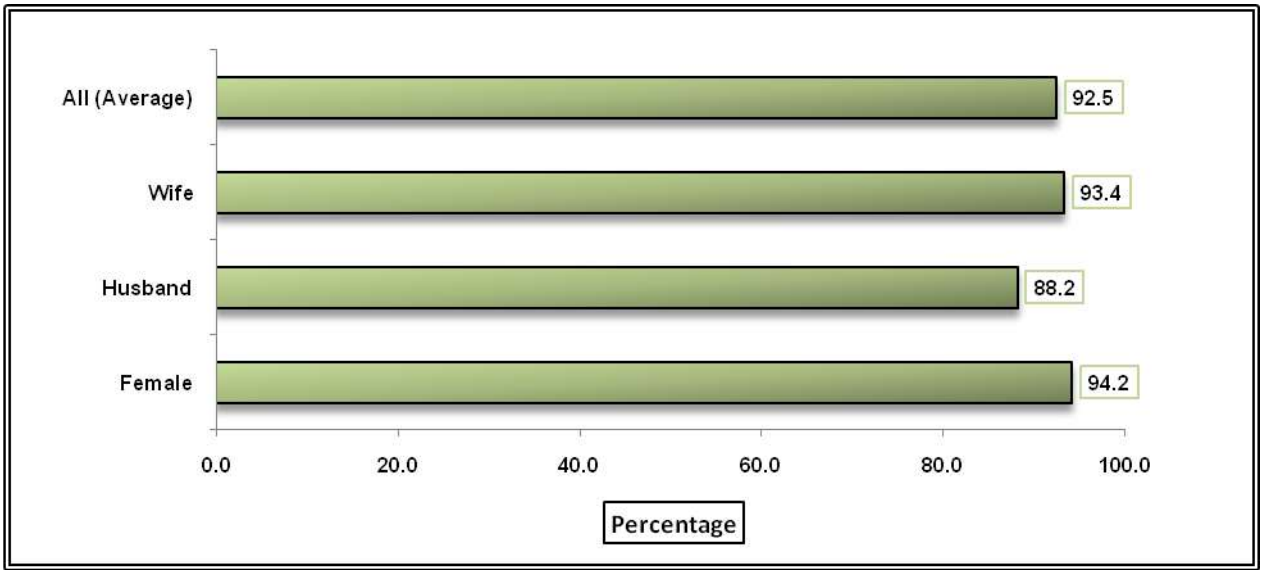
Knowledge about preparing oral saline (ORS):

The survey data shows that majority of respondents know how to prepare oral saline. Center wise and gender wise response pattern are similar.

Incidence of washing hands after using toilet:

Overall 92.5% respondents wash hand after defecation shown in Figure-19. No major difference can be noticed in proportion of responses among centers. Among genders, 88.0% male respondents informed that they wash their hands after defecation which is lower than the proportion of female respondents (wife=93.4%, female=94.2%).

Figuire- 19: Incidence of washing hands after using toilet[Q21d]



2.18 Acute Respiratory Infection (ARI) / Pneumonia

Awareness about causes of children being affected by pneumonia:

Table-15: Awareness about causes of children being affected by pneumonia [Q22a]

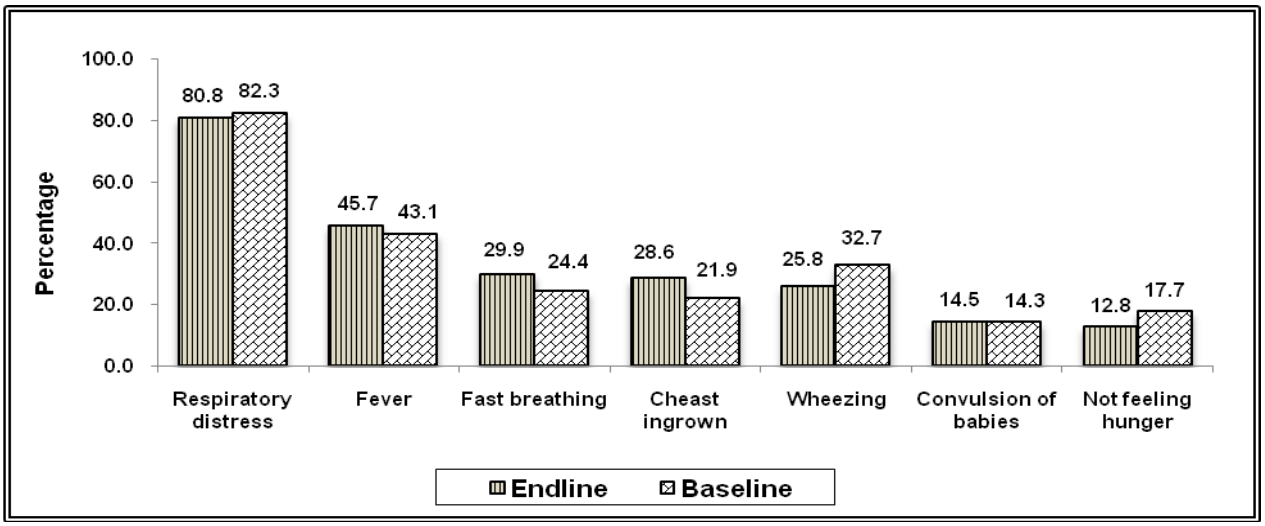
	End-line (%)	Baseline (%)
Cold	87.1	91.7
Fever occurs	1.5	0.0
From dust	0.6	0.2
If timely vaccination not taken	0.2	0.0
Not remaining neat and clean	0.2	0.0
Taking unhygienic foods	0.1	0.1
Unaware	12.0	8.3
Base t All Respondents	**2,350**	**1,850**

It revealed from the end-line study that most of the respondents (87.0%) know that children get W v µ u } v] (Œ } u Z } o [X d Œ v • Œ •] u] o l Œ] v] l š Z . P Z • š µ o f] • ~ unaware respondents has increased by about 3.0% points in end-line from baseline figures.

Symptoms of pneumonia:

It revealed from the study that both in end-line v] v • o] v U Z Z • ‰] Œ š } Œ Ç] • š Œ • • Ç u ‰ š } u } (‰ v µ u } v] ~ ô ì X ì 9 v } À • X d Z ‰ Œ } ‰ } Œ š] } v } (Z Z decreased by 1.0% points in end-line from baseline figure which is nominal. However, percentage] • š Œ] µ š] } v } (o o } š Z Œ • Ç u ‰ š } u • Z À [w h i c h h a s d e c r e a s e d b y 6 . 0 % p o i n t s i n e n d - l i n e from baseline (Figure- 20). Among centers and among genders response pattern is similar.

Figure- 20: Symptoms of pneumonia [Q22b]

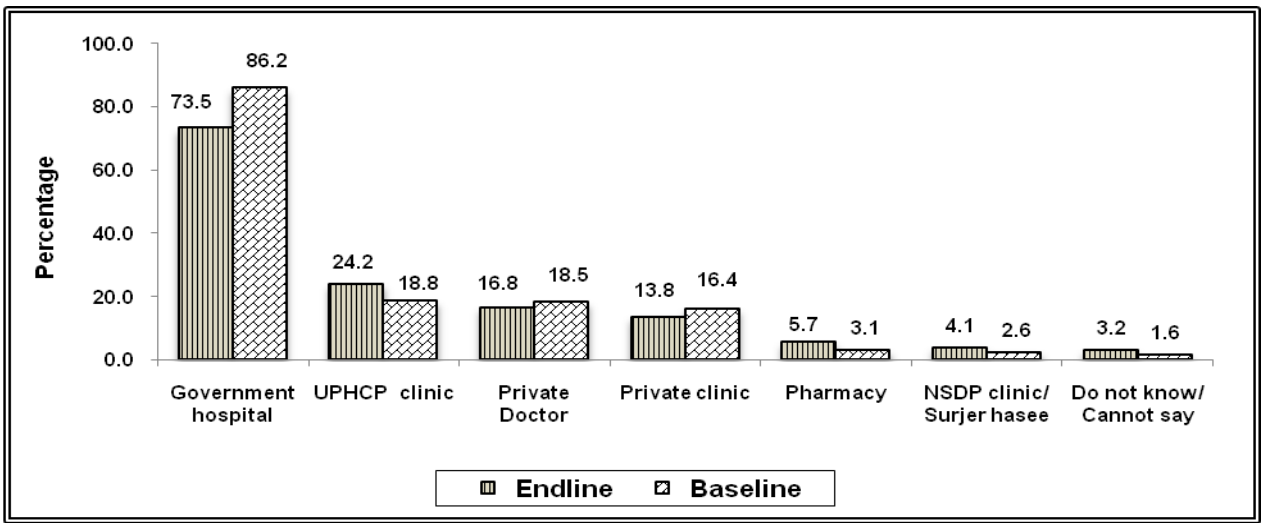


Steps need to be taken to prevent pneumonia:

The end-line study shows that more than half of the respondents have informed that it is needed Z o put warm clothes [to prevent pneumonia. The other mentionable measures are Z d } • š Ç] v µ • š v • (Œ v À] Œ Ù v Z ø š [v } o (Œ } u v } • [U v } š š } Æ ‰ } • Ç š } } o [U Z Among centers, responses are largely varied.

Plcae where pneumonia affected family mebers needs to be taken for treatment:

Figure- 21: Plcae where pneumonia affected family mebers needs to be taken for treatment [Q22d]



The end-line survey shows that a greater part of the respondents (73.0%) answered that pneumonia patients should be taken to Government hospital. In baseline, more respondents (86.0%) had stated this option. Again, more respondents in end-line Z À } v •] Œ -II Z h W s, (end-line=24.0%, • o] v A í õ X ì 9 • [(} Œ š Œ š u s v š } (‰ v s u] v [center-wise, response pattern is almost similar (Figure- 21).

2.19 Knowledge about Tuberculosis (TB)

Knowledge about tuberculosis:

T Z Œ • ‰ } v š [knowledge level about Tuberculosis has slightly decreased as compared to baseline. However, the awareness rate has increased in Dhaka and Sirajganj and has decreased in all other districts from baseline to end-line.

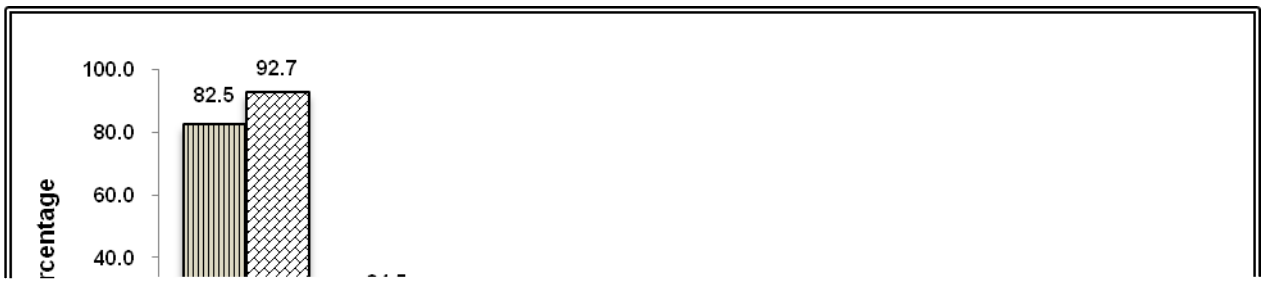
Primary symptoms of tuberculosis:

About half of the Œ • ‰ } v v š • • š š Z o } } } Ì • } µ š Á] š Z } µ P Z [• ‰ Œ] u
The other stated symptoms Œ Z (Œ š ‹ µ } µ P Z u h ‰ Œ •] • š • u } Œ š Z v ï Á l • [
} u ‰ v] Ç (À Œ [U š X

Places of availabnilty of tuberculosis treatment:

The end-line study shows that most of the respondents (83.0%) have answered that Tuberculosis patients should be taken to Government hospital. In baseline, more respondents (93.0%) had stated this option. P] v U u } Œ Œ • ‰ } v v š • U P H À P-II } o v] • v] • Œ [(} Œ š Œ š u v š } (š µ Œ µ o } • during end-line survey (end-line=25.0%, baseline=17.0%). Center wise response pattern is almost similar.

Figure- 22: Places of availabnilty of tuberculosis tratment [Q23c]



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Final Report

Second Urban Primary Health Care Project

June 18, 2012

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Second Urban Primary Health Care Project
Dhaka

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Dhaka