Evaluation of the Integrated Community Development Project (ICDP) Supported by UNICEF in the Chittagong Hill Tract (CHT) Districts

Final Report

Submitted to

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1. EXECUTIVE SUMMARY:

The Chittagong Hill Tracts (CHT) is among the most disadvantaged and isolated areas in Bangladesh. The CHT is divided into three districts – Rangamati, Bandarban and Khagrachari - comprising 25 Upazilas and covering a total of 1.4 million people. Most of the people live in small villages known as *paras*. There are a total of 4,599 *paras* in the CHT and each of these consists of 20-100 families.

Between 1997 and 2010, ICDP constructed a total of 2520 para centre and planned that by end of 2011 there will be a total of 3500 in the three CHT districts to provide a range of services including organization of early childhood development sessions for pre-school children, health and hygiene education activities to promote immunization, anemia prevention, use of safe drinking water and sanitation, hand washing and other community development activities.

The purpose of the project had been to improve the socio-economic conditions of the children and mothers of the disadvantaged families of CHT through providing basic services of health, nutrition, education, water and sanitation and micro-credit. Though the micro-credit aspect of the project has been handed over to the government within the last five years, it is still considered as part of the Integrated Community Development Project.

At this point UNICEF initiated an evaluation of the project with a view to assess it performance focusing on its project relevance, effectiveness, efficiency and sustainability.

This study was conducted through primary data collection and secondary review of the last evaluation report "Evaluation of the UNICEF Integrated Community Development Project in the Chittagong Hill Tracts, Bangladesh" conducted by Nordic Consulting Group a/s in 2007. Primary data collection was done through household survey of 2210 respondents, Para worker survey of 340 sample, 9 focus group discussions (FGD) and 15 case studies.

Relevance:

The project relevance was always there and will be there beyond doubt. Findings reveal that contribution of the project in the intervention area was enormous in promoting health and hygiene, creating awareness about nutrition and imparting education, especially to children. Survey findings show a significantly better situation in the intervention areas against all these parameters compared with non-intervention areas. Therefore, it is essential that the project is expanded to non-intervention areas and keep going in the intervention areas in order for it to sustain. Otherwise the community is not likely to be able to hold on to the achievements made so far.

Effectiveness:

As indicated above the project was found quite effective. People in the intervention areas of all three Hill Districts were more aware about their health, more people were visiting health center or hospital for healthcare service, usage of mosquito net was almost universal, consumption of iodized salt was more than 90%, awareness and usage of safe water and hygiene practice was significantly higher than non-intervention area. Besides, it has successfully reduced child illiteracy through its preschool operation, making them ready for graduating to primary school. Findings revealed improved percentage of pupil presence at the preschools on data collection day in this survey compared with the last evaluation survey. Special mention may also be about

consuming iodized salt and nutritional issues which are parts of the focus areas of ICDP. Most women were found aware of the benefit of taking and risk of not taking iodized salt and benefits of milk, egg, green vegetables and fruits. Besides, for purchasing and setting up and of latrine, Para worker was the most mentioned source of motivation in intervention areas Training on how to use a latrine was also imparted most by the Para.

Efficiency:

The project was also found quite efficient, and the following findings would speak for such efficiency:

Household survey:

Almost all of the respondents, both males and females, were aware of the functions of Para center, especially about 'Preschool classes', 'Health and nutrition information' and 'Water & Sanitation'. About 95% of either the respondents or any of their respective family members visited Para center for some specific purpose in the last 6 months. Everybody of those who visited Para center found the Para workers helpful, and all of them were comfortable approaching and liaising with them. By far the most mentioned benefit was 'Child education' mentioned by more than 90% respondents. Other mentionable benefits were gaining 'Knowledge about healthcare' & 'Knowledge about nutrition and creating 'Awareness for pregnant women'.

Courtyard meetings are held regularly, and almost all females attended such meetings where they discuss about iodized salt other nutritional issues. As a consequence of the project around 90% of respondents were found to visit health center or hospital for healthcare service. Usage of mosquito net was almost universal and consumption of iodized salt was more than 90%

Water and Sanitation condition was much better in intervention area than in non-intervention area with regard to using safe water and sanitary latrine. In intervention area 92% latrines were observed by the enumerators as against 69% in non-intervention area. Out of the observed latrines, 80% and 77% respectively were found clean. Soap was available around 73% and 57% observed latrines respectively, and ash in 10% and 13%. Neither soap nor ash was available in 17% and 30% latrine respectively. Water container was available in 71% and 37% of the observed latrines, and of the available containers 95% and 93% contained water in intervention and non-intervention areas respectively. These all indicate better hygiene practice in intervention area. After defecation, little more than 80% respondents in intervention area claimed to use soap for washing hand irrespective of gender, as against little above 50% in non-intervention area, followed by water only (14% and 33% respectively). Most of the rest use ash (more in non-intervention area).

Households free from human and animal faeces were much higher (85%) in intervention areas compared with non-intervention areas (68%). Similarly, households free from garbage or garbage is stored in a designated place was significantly higher in intervention areas (76%) than in non-intervention areas (55%).

Para Center Survey:

Most commonly rendered services were preschool classes and health & nutrition information. Other major services included W&S demonstrations (e.g. latrine installation), immunization information, demonstrations of safe water and hygiene, Para information centre, provision of micronutrient supplement, meeting venue, nutrition demonstration and Skill development with varying degrees across districts.

All the community information charts were being displayed in about 80% or more of centers, and most of the displayed information/charts were found legible, clear and up to date. Besides, in most cases (90% or more) Para Center Children attendance register, Review by Supervisor on last visit and Para Center Stock register were available with record date (as applicable) and up to date.

In most of the centers education and play materials were found available and in majority cases these were in good condition. Date of birth and gender of children were also available in most (more than 95%) centers.

Almost all women who gave birth were given vitamin A within 6 weeks of delivery. However, not all children appear to have been given vitamin A or fully immunized as can be seen from the following tables.

About two-thirds of Para workers reported to have received training on preparing action plan for Water & Sanitation for the community, and the rest opined otherwise.

Courtyard meetings are held every fortnightly. Besides, every Para Center has a management committee, and in the last 6 months almost all of them had 3 meetings on average.

Para workers also attended cluster meeting, and attended three such meetings on average in the last 6 months.

Para workers seem to raise Para center related issues with their respective supervisors when they visit the center. When supervisors visit Para center, they also meet with PCMC, headman, attend courtyard meeting ECD class. Para workers appear to learn something from the supervisor in every visit of the supervisor.

On an average week a Para worker works for 6 days, spends 18 hours a week and visits 6 households. About one-fourth of the workers perform additional activities other than ones performed as Para worker. Major such activities included Teaching children at home, Working along with health workers, Accompanying sick persons in the community to health facility and Taking part in national vaccination program.

Sustainability:

The project has been well accepted and appreciated by the people of Hill Tracts due to its contribution in enhancing their living standard through creating awareness about health and hygiene, nutritional needs, reducing illiteracy, etc. The community also wants the project to continue. This indicates high probability of the project sustainability from demand side. However, while the community people want the project to continue, it is highly unlikely that it will sustain without outside assistance. Even for paying wages for the Para workers, only about one-third of them thought that the community would contribute, let alone the center. In reality amount of contribution will most likely be negligible. While the demand side meets the

prerequisite for the sustenance of the project, ensuring the supply side needs to be considered by the relevant authority.

FGD:

The salient findings from the group discussions are as follows:

- The relevance of the project is evident. There was and still is a high demand for increased community awareness about early child development and education, about health and nutrition and about water, environment and sanitation.

- It revealed through the discussion that Para center now become a focal place of all social activities. Overall, the project is being managed with efficiency and it revealed from the discussions that the administration of the para centers is well managed.

- Community people are satisfied with the management and efficiency of the Para Workers and Centers as a whole.

- The community involvement has been increased which is the indicator of sustaining of this project.

- The evaluation reveals that the targeted women and children have access to services provided by para centers and this has increased a lot over the years. The intended beneficiaries of the project have actually benefitted.

- From the group discussion it was learnt that the Para Center and Para Workers are the integral part of the people and they are being benefited, not just looking from outside but this is the feeling of the people themselves. They want to see the Para centers providing more and more services and they are now aware of their healthcare, children's education, sanitation and waste disposal and decent way of living.

- The lesson learnt is any integrated community development project with close follow up is bound to produce tangible results and people are benefited beyond doubt. Therefore, replicability of such programs can hard be over emphasized and that too in context to Chittagong Hill Tract Districts.

Case Stories:

It reveals from the case stories that the CHT district people are still very superstitious. They believe in many supernatural things and miracles that can be caused by *Ayurvedic* doctors, quacks and so-called religious persons. Therefore, when they fall sick they go to these people instead of going to clinics and hospitals. They are still shy about community people's comments when they sometime take their wives to clinics / hospitals where possibly male doctors could attend. To remove all these, extensive awareness building programs need to be undertaken. In poor populated areas free treatments need to be given. More non-intervention areas need to be covered where people still live under extreme poverty level.

Major Conclusions:

Para center project appear to have done tremendous jobs especially in terms of pre-school child education, paving the path for onward education, promoting health and hygiene and creating awareness about nutrition amongst the target population. On matters of health and hygiene findings reveal significant difference between intervention and non-intervention areas, indicating commendable performance of the project. It needs to keep up the good work.

Para workers' pre-school activities, record keeping, display of information and charts, regular holding of courtyard meeting, attending cluster meetings, etc. speak for their dedication. More frequent visit by the supervisors and close supervision would motivate them to deliver better. Besides, education and information materials need replacements on a regular basis due to damage caused by normal wear and tear.

Safe drinking water for preschool children at the center is a genuine concern. It is therefore imperative that the same be made available through tube well at every Para center.

The project has been well accepted and appreciated by the people of Hill Tracts. However, as indicated earlier, it is highly unlikely that it will sustain without outside assistance. Therefore, relevant authority would need to find other sources for necessary fund to keep the project going.

Majority of the centers have suffered from normal wear and hence and require immediate repair, especially of wall/fence. It may be a good idea to do routine maintenance work to make them last long.

Although Para workers were found quite efficient in delivering their services, they need motivation and skill trainings, especially in areas of health to improve their level of efficiency and to ensure even better service delivery, especially on preparing community action plan for Water & Sanitation as a large number of Para workers did not receive this training.

2. BACKGROUND:

The Chittagong Hill Tracts (CHT) is among the most disadvantaged and isolated areas in Bangladesh. The CHT is divided into three districts – Rangamati, Bandarban and Khagrachari- comprising 25 Upazilas and covering a total of 1.4 million people. Most of the people live in small villages known as *paras*. There are a total of 4,599 *paras* in the CHT and each of these consists of 20-100 families.

In 1972 UNICEF started its support to the CHT as part of its Country Programme Implementation in Bangladesh. In 1991, UNICEF and the government of Bangladesh jointly formulated a project entitled, "Integrated Community Development Board (CHTDB) under the Ministry of Chittagong Hill Tract Affairs (MCHTA).

The purpose of the project is to improve the socio-economic conditions of the children and mothers of disadvantaged families of CHT through provision of basic services of health, nutrition, education, water and sanitation and micro-credit. Although the micro-credit component of the project was handed over to the government since 2006, it is still considered as part of the Integrated Community Development Project.

Between 1997 and 2010, a total of 2520 para centre were constructed and it is planned that by end of 2011 there will be a total of 3500 in the three CHT districts. 3500 para Workers- mainly females have been trained to run the para centre. The para worker provides a range of services including organization of early childhood development sessions for pre-school children, health and hygiene education activities to promote immunization, anemia prevention, use of safe drinking water and sanitation, hand washing and other community development activities. Each para centre is supported by a para centre Management Committee (PCMC) comprising 5 community members including the para worker. They ensure that the para centre is fully functional with the active participation and ownership of the community members.

2.1. Integrated Community Development Project (ICDP):

The Chittagong Hill Tracts Development Board (CHTDB) was created in 1976 with the aim of improving the socio-economic condition of the region. Since its inception, CHTDB has been implementing projects or schemes in a number of sectors, including, Agriculture, Communication, Education, Sports and Culture, Social Welfare, Socioeconomic Rehabilitation, Community Development and Cottage Industries.

In 1991, UNICEF and the government of Bangladesh jointly formulated a project entitled, "Integrated Community Development Project". This project has since been under the direct supervision of the Chittagong Hill Tracts Development Board (CHTDB) with the responsible line ministry being the Ministry of Chittagong Hill Tracts Affairs (MCHTA). It has been administered by Project Directors, Project Coordinators and Project Organisers, at different levels.

In 1996, the project underwent a strategic change in its focus, with services being provided at the lowest community level – the *Para* (village) by *Para* Centres. Between 1997 and 2010, total of 2520 *Para* Centres were constructed in different *Para*s in the three CHT districts

The *Para* Centres were constructed in the vicinity of, or in the centre of, the *Para*s. Communities provided the land, the labour and the basic materials for the construction of the

centres, whilst UNICEF provided the roofing material (corrugated iron sheeting), education materials for pre-school training and the basic training for Project Organisers and *Para* Workers. The *Para* Worker (usually a female community member) was selected from the community to manage the centre and provide community level services, including information on health, hygiene and nutrition services (preventive), promotion of using safe drinking water and sanitation services, and early childhood development for pre-school children. In some remote *Para*s, the *Para* Worker also offered teaching primary classes.

A *Para* Centre Managing Committee (PCMC), composed of five community members including the *Para* Worker, was formed to ensure the effectiveness of the *Para* Centre activities and to allow the *Para* Centre to be utilized as a venue for other community development activities.

The network of 2,520 *Para* Centres is continuing to be managed by the ICDP staff under the direct supervision of the Chittagong Hill Tracts Development Board (CHTDB). According to the Peace Agreement, it was envisaged that the project would come under the government of the Regional Council and under the administration of the Hill District Councils. However, up to the present time, the project has not been integrated into the District Councils.

UNICEF has been supporting ICDP financially and technically from its inception. A UNICEF Divisional Programme Officer based at Rangamati facilitates the implementation of the project, including regular monitoring of implementation status and assessment of training needs for *Para* Workers. District Programme Officers are based at the other two districts (Bandarban and Khagracheri) to monitor the implementation of the project.

One of the prime objectives of ICDP has been to facilitate the services of different governmental and non-governmental agencies through *Para* Centres and through different sectoral interventions, as presented in the following table:

	Intervention
Health and nutrition	Training of *Para* Workers; routine immunisation programmes; post-natal Vitamin A supply; awareness building in communities on infections and clinical management of different waterborne infections
Water and sanitation; WES project	Installation of facilities; awareness building on safe water, environment and sanitation; limited number of Upazilas covered by UNICEF WES programme
Child development and education	Early child development intervention; pre-school training
Child protection and promotion of gender equality	Training on Convention of Child Rights; Gender development and intervention for adolescent girls
Monitoring, planning and communication	Communication material; training on planning and monitoring for *Para* Centres

The purpose of the project had been to improve the socio-economic conditions of the children and mothers of the disadvantaged families of CHT through providing basic services of health, nutrition, education, water and sanitation and micro-credit. Though the micro-credit aspect of the project has been handed over to the government within the last five years, it is still considered as part of the Integrated Community Development Project.

2.2. Purpose of the Assignment:

The purpose of the assignment is to:

- Review the experience of the ICD
- Assess the project relevance, effectiveness, efficiency, sustainability
- Assess the progress of implementation of the currently ongoing ICDP project.
- The findings, lessons and recommendations from this evaluation will be used to adjust the project design, approach and strategies to ensure its sustainability and progress of implementation of the currently ongoing ICDP project.
- The evaluation will highlight the main achievements in the last five years and UNICEF's contribution in terms of outputs and progress made in achieving outcomes in the areas of intervention.

2.3. Scope of this Study:

This study covered primary survey of households in the intervention and non-intervention areas and Para workers in the intervention areas, and review of "Evaluation of the UNICEF Integrated Community Development Project in the Chittagong Hill Tracts Bangladesh - 2007", conducted by Nordic Consulting Group a/s and comparison against its findings.

Broad issues addressed:

Household survey:

- Socio-demographic profile
- Utilization of Para center (Efficiency)
- Health and nutrition
- Water and sanitation
- Micro finance
- Opinion and recommendation about Para center and worker

Para worker survey:

- Socio-demographic profile
- Employment history and remuneration
- General information Para center
- Micro finance
- Infrastructure of Para center
- Community related information
- Pre-schooling and profile of pre-school children
- Para center input checklist
- Graduation from pre-school to primary school
- Health and nutrition
- Disease preventive measures
- Water and sanitation
- Courtyard meeting
- Para center management committee (PCMC)
- Cluster meeting
- Supervision of Para worker
- Other activities/duties of Para worker
- Opinions and comments of Para worker

3. STUDY APPROACH AND METHOD:

The study was conducted through primary data collection and secondary review of the last evaluation report "**Evaluation of the UNICEF Integrated Community Development Project in the Chittagong Hill Tracts, Bangladesh**" conducted by Nordic Consulting Group a/s in 2007.

In order to collect primary data two approaches were followed:

- **Quantitative, and**
- **Qualitative**

3.1 Quantitative Approach

Quantitative approach used face to face (F2F) interview method with the community household members with the help of a semi-structure questionnaire.

3.2 Qualitative Approach

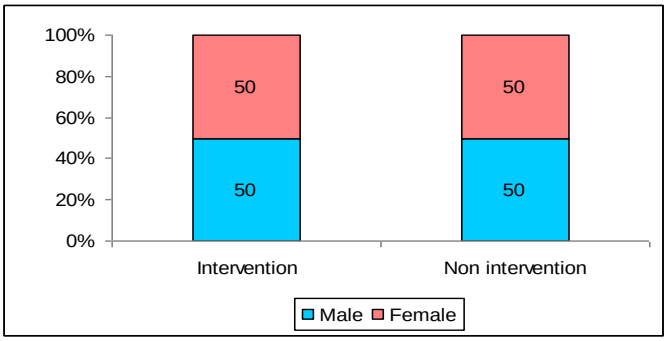
Qualitative Approach included:

- Literature Review;
- Focus Group Discussions (FGD);
- In-depth interview, and;
- Case study.

3.3. Sample Size and Distribution:

	Rangamati	Bandarban	Khagrachari	Total
No. of Upazila	4	2	2	8
No. of para (intervention)	129	89	122	340
No. of para (intervention)	20	14	19	53
Household (Intervention area)	645	445	610	1700
Household (Non-Intervention area)	194	133	183	510
Total Household	**839**	**578**	**793**	**2210**
Para Worker	129	89	122	340
FGD	3	3	3	9
Case Study	5	5	5	15

Gender distribution of household respondents:



3.4. Sampling Method:

Household interview	In order to make it representative, systematic random sampling technique was used to conduct household survey. All three hill districts were covered. Specified number of Upazilas was selected randomly. In selected Upazila, specified number of Paras was also selected randomly. While 5 interviews were conducted in each Para in intervention areas, in non-intervention areas 10 interviews were conducted. In selected Paras, a starting point was selected randomly, and then every 'n'th household was selected for interview, diving total household by 5 and 10 in intervention and non-intervention areas respectively. In a selected household an eligible respondent was selected randomly for interview.
Focus Group Discussions (FGD)	Convenient through screening for eligibility
In-depth interview	Para worker of selected Paras
Case study	Convenient through screening for eligibility

3.5. Data Collection and Data Processing:

3.5.1. Household and In-depths:

Questionnaires: Essentially the baseline questionnaires with some additional relevant questions were used to conduct the survey. The final questionnaires were approved by UNICEF.

Selection of Enumerators & Training:

Required number of enumerators was selected from the Hill District areas for language and geo familiarity considerations. These enumerators were trained in the following manner to undertake the survey:

- Identified sufficient number of enumerators as per the required qualifications and experience.
- Prepared a training manual that narrated background and objective of the survey, manners and etiquette, do's & don'ts, explanation of and instruction on each and every question, description of behavioral conduct before, during and after the interview with tips on how to handle difficult situations, etc.

The basic training ran for at least two days and included:

- debriefing on the objectives of the study, quality control mechanisms, and overall conduct of the project;
- detailed explanation of each question, so that enumerators are able to interpret all questions consistently, and ask all questions in the prescribed manner with informed explanations to help respondents in case of difficulties;

- instruction on how to properly fill out the questionnaires (convention for numeric variables, importance of legal values, how to differentiate and write replies such as not applicable, refused to respond, don't know, and so on);
- issues related to data entry and checking of questionnaires;
- techniques to secure participation, interviewing techniques, how to handle difficult situations and common occurrences, probing, etc.;
- mock interviews to test the enumerators;
- Logistics and schedules.

The enumerators were also be briefed clearly about their duties which include:

- visit the selected household and ensure their participation;
- conduct face-to-face interviews with the selected respondents;
- record accurately the answers; code the questionnaires accordingly;
- ensure completeness and accuracy of answers; perform accuracy checks on the questionnaires;
- ensure security and safety for the completed questionnaires;
- deliver completed questionnaires to supervisors; and
- Safeguard the confidentiality and privacy of the collected information.

Duties of Survey Supervisors Relating to Data Collection:

The duties of the supervisors relating to data collection were to:

- Promptly control first few interviews by each interviewer, and, if necessary, provide additional training, and if necessary replace interviewers.
- Collect the incoming completed survey forms and conduct 100% check for incomplete, omitted or otherwise erroneous data recording practices on their source. If necessary replace unsatisfying interviews with properly conducted ones, or ensure that requested answers are gathered from the target respondents;
- Conduct 5% random back check of each interviewer completed interviews. Provide all logistical support and material to enumerators; and
- Approve questionnaire for data entry ensuring that the assigned enumerators did not overlook inconsistencies and skip patterns.

Quality Control (Call backs and scrutiny): Survey supervisors checked all completed questionnaires and conducted a minimum of 15% percent call-backs in order to verify the accuracy of the data recorded and, where deemed necessary as below:

- Physical call back 15%
- Some response verification 10%
- Check filled-in questionnaire 100%

Data Processing:

Data entry was done electronically by our trained and experienced data entry operators. Tables were generated as per the analysis plan. Data analysis was done by intervention and non-intervention areas, district and male & female.

3.5.2. FGD:

FGD guide and moderation: All group discussions were conducted by senior OrQuest moderators. Prior to the commencement of fieldwork, a discussion guide was developed and agreed with UNICEF. All group discussions were tape-recorded, which were transcribed verbatim and checked for accuracy by the executive.

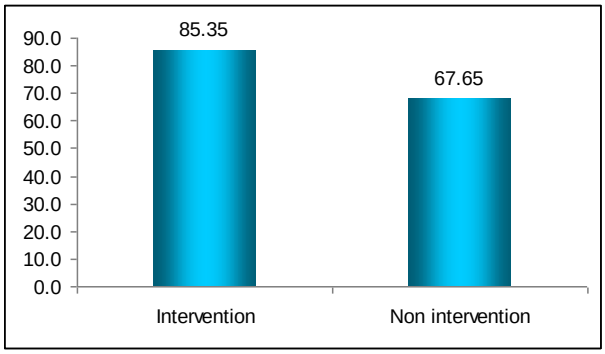
Analysis: Each tape was content-analyzed. The report incorporated all the findings of the research, the analysis and interpretation and also quotes from the discussions. Analysis was made by location/area to see if there are differences between the types of respondents.

4. HOUSEHOLD SURVEY:

Household cleanliness:

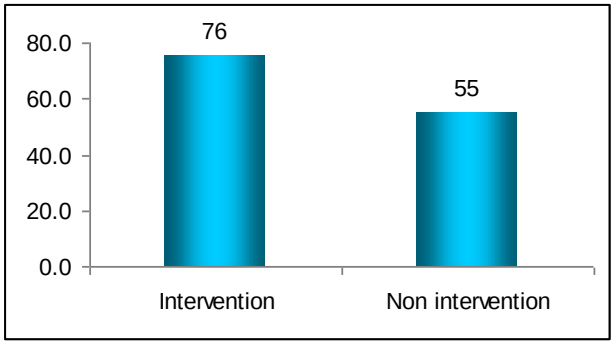
Households free from human and animal faeces were much higher (85%) in intervention areas compared with non-intervention areas (68%). Similarly, households free from garbage or garbage is stored in a designated place was significantly higher in intervention areas (76%) than in non-intervention areas (55%).

Graph-1: Incidence of area around the house free from human and animal faces



Graph-2: Incidence of area around the house free from garbage or garbage is stored in a designated place

Figure in %



Profile of respondents:

Respondent's status in the family: In both intervention and non-intervention areas father and head of family jointly constituted about half of the respondents, followed by mother (44% in both areas). The others constituted around 10%. However, head of households were almost universally males.

Table-1: Status in the family

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Head	44.2	1.8	23.0	51.0	0.4	25.7
Father	44.9	0.0	22.5	34.9	0.0	17.5
Mother	0.0	87.3	43.6	0.0	87.1	43.5
Others	10.8	10.9	10.9	14.1	12.5	13.3
Base - All Respondents	850	850	1,700	255	255	510

Age of respondents: Age-wise respondents in non-intervention areas were much younger than in intervention areas. However, compared to males, females were younger than their counterpart.

Table-2: Age of the respondent

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
15-19 years	1.3	3.1	2.2	27.1	27.8	27.5
20-29 years	16.6	38.6	27.6	14.9	32.5	23.7
30-39 years	36.0	37.3	36.6	26.7	23.1	24.9
40-39 years	25.8	14.5	20.1	15.3	11.0	13.1
50-59 years	14.5	4.8	9.6	8.2	3.1	5.7
60+ years	5.9	1.8	3.8	7.8	2.4	5.1
Base - All Respondents	850	850	1,700	255	255	510

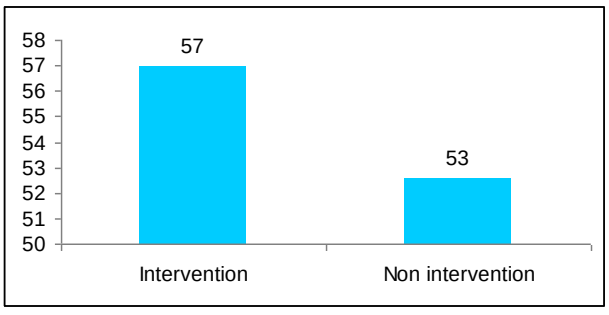
Marital status: More than 90% of the respondent irrespective of gender and area were married.

Table-3: Marital status

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Unmarried	5	4	5	7	5	6
Married	94	94	94	91	93	92
Widowed	1	1	1	1	2	1
Divorced	0	0	0	0	0	0
Base - All Respondents	850	850	1,700	255	255	510

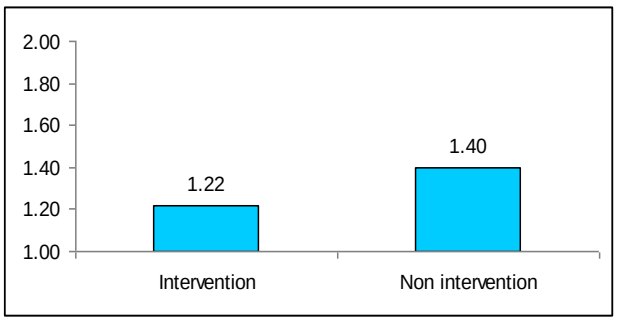
Incidence of children in family and average number: Incidence of children living in household was a little higher in intervention are (57%) than in non-intervention area (53%) Average number of children in intervention area was less (1.22) per household than in non-intervention area (1.40).

Graph-3: Incidence of children living in household



Graph-4: Number of children living the household

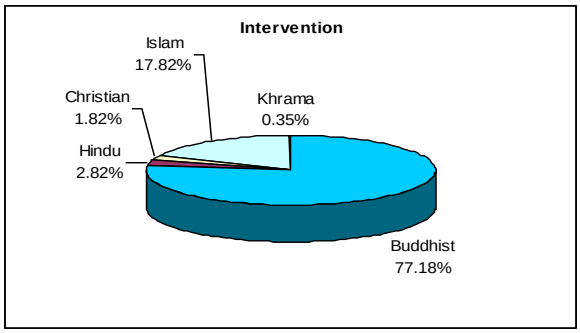
Figure in %

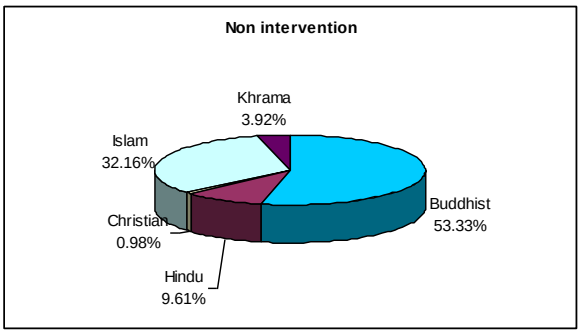


Religion: Buddhists dominate in both intervention (77%) and non-intervention area (53%), followed by Muslims (18 and 32% respectively). However, as can be observed, percentage of

Buddhist in intervention area was much higher than in non-intervention area and opposite is the case for Muslims. Christians, Khramas and Hindus make up the rest.

Graph-5: Religion of respondent





Ethnicity: Ethnicity-wise, in intervention area Chakma and Marma make up 70% of the population (35% each), followed by Bangali (19%), and the rest are Tenchungya, tripura, Murong, etc. On the other hand, in non-intervention are Bangalis constitute single most ethnic group (38%), followed by Marma (26%) and Chakma (24%). The others make up the rest.

Table-4: Ethnic or tribal group of respondent's family

	Intervention			Non intervention		
Ethnicity	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Chakma	34.4	35.5	34.9	22.4	22.4	22.4
Marma	37.8	33.9	35.8	25.5	26.3	25.9
Tripura	2.7	2.7	2.7	5.1	4.3	4.7
Bangali	18.0	20.2	19.1	37.6	37.6	37.6
Tenchungya	6.1	6.8	6.5	4.3	3.9	4.1
Khyang	0.5	0.1	0.3	0.0	0.0	0.0
Murong/ Mro/ Mru	0.4	0.2	0.3	4.7	3.5	4.1
Saontal	0.2	0.5	0.4	0.0	0.0	0.0
Base - All Respondents	850	850	1,700	255	255	510

Utilization of Para center:

Awareness of the functions of Para center: Both males and females were found equally aware of the functions of Para center. Most mentioned function was conducting 'Preschool classes', closely followed by providing 'Health and nutrition information'. Other major functions mentioned were 'Demonstrations (safe water and hygiene)' 'W&S demonstrations (e.g. latrine installation)', 'Immunization information', 'Arranging meeting venue', 'Information centre', Providing of micronutrient supplement' and 'Nutrition Demonstration (e.g. kitchen garden)' as can be seen from the following table.

Table-5: Awareness of the functions of the Para Centre

	Male	Female	All
	%	%	%
Preschool classes	94.0	94.7	94.4
Health and nutrition information	87.5	89.2	88.4
Demonstrations (safe water and hygiene)	55.3	64.1	59.7
W&S demonstrations (e.g. latrine installation)	59.5	59.1	59.3
Immunization information	50.6	55.3	52.9
Meeting venue	48.2	48.5	48.4
Para information centre	35.4	36.9	36.2
Provision of micronutrient supplement	24.6	30.8	27.7
Nutrition Demonstration (e.g. kitchen garden)	21.9	20.0	20.9
Skill development	11.5	9.2	10.4
Micro credit disbursements	1.8	2.1	1.9
Family planning Related Information	0.2	0.0	0.1
Advice during pregnancy	0.1	0.0	0.1
Base - All Respondents	850	850	1,700

Incidence of visiting Para center in last 6 months and purpose: About 95% of either the respondents or any of their respective family members visited Para center for some specific purpose in the last 6 months. No difference was observed between male and female respondents. Most mentioned purpose of visit was to attend 'Preschool classes' closely followed by for 'Health and nutrition information'. Others included 'W&S demonstrations (e.g. latrine installation)', 'Demonstrations of safe water and hygiene', 'Immunization information', 'Attend meeting', 'Visit Para information centre', 'Nutrition Demonstration (e.g. kitchen garden)', 'Collect micronutrient supplement' and for 'Skill development' as can be seen from the following table. No major variation was observed in responses between males and females.

Graph-6: Incidence of Para Centre in last 6 months by the respondent or any family members

Figure in %

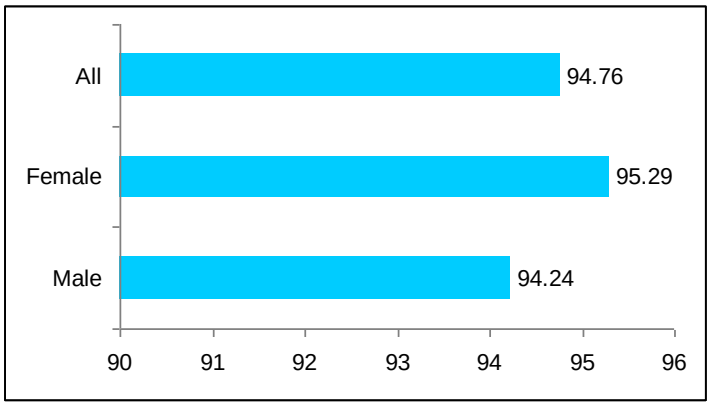


Table-6: Purpose of visiting Para center

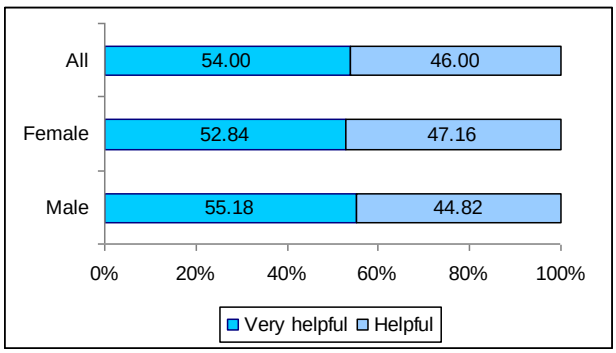
	Male	Female	All
	%	%	%
Preschool classes	67.92	72.42	70.18
Health and nutrition information	64.77	67.27	66.02
W&S demonstrations (e.g. latrine installation)	39.10	37.41	38.25
Demonstrations of safe water and hygiene	35.11	40.05	37.59
Immunization information	31.60	37.05	34.34
Meeting venue	30.39	33.81	32.11
Para information centre	23.97	24.34	24.16
Nutrition Demonstration (e.g. kitchen garden)	17.31	14.63	15.96
Provision of micronutrient supplement	12.95	18.71	15.84
Skill development	7.51	6.83	7.17
Micro credit disbursements	0.85	1.20	1.02
Base - Those visited to para centre	801	810	1,611

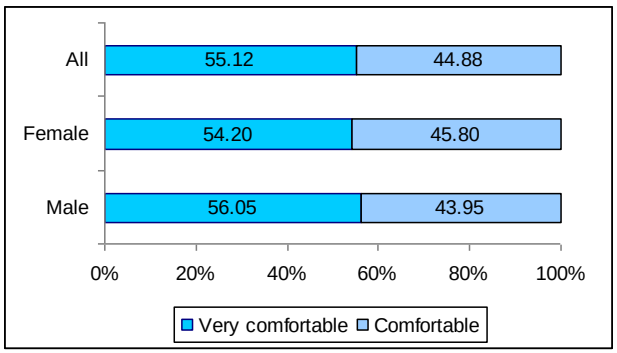
Helpfulness and friendliness of PW: Everybody of those who visited Para center found the Para workers helpful and friendly, and all were comfortable approaching and liaising with them. None felt otherwise.

Graph-7: Helpfulness of Para Worker

Graph-8: Friendliness (comfort in approaching and liaising with PW)

Figure in %





Benefits derived from Para center: A number of benefits were mentioned by the respondents that they derived from Para center. By far the most mentioned benefit was 'Child education' mentioned by more than 90% respondents. Other mentionable benefits were gaining 'Knowledge about healthcare' & 'Knowledge about nutrition' and creating 'Awareness for pregnant women'. A few others were also mentioned but not as prominently, as can be seen from the following table.

Table-7: Benefits derived from Para center

	Male	Female	All
	%	%	%
Child education	93.4	89.3	91.4
Knowledge about healthcare	32.7	34.0	33.4
Knowledge about nutrition	16.1	16.9	16.5
Awareness for pregnant women	16.6	14.8	15.7
Awareness about use of hygienic latrine	9.6	9.3	9.5
Awareness about cleanliness and hygiene	7.4	8.7	8.1
Knowledge about vaccination	6.5	8.0	7.2
Safe use of water	5.8	5.2	5.5
Vaccination for women	4.1	4.4	4.2
Vitamin 'A' for children	4.5	3.9	4.2
Others	12.8	12.6	12.7
Base - All Respondents	850	850	1,700

Suggestions for further improvement: Quite a few suggestions were put forward by the respondents for further improvement of Para center activities. Major ones were providing 'School dress/winter clothes to children every year', 'snacks/biscuits everyday' and 'fresh water to children in Para Center always'.

Mostly could not mention any new activity that could be included as additional function. However, a few mentioned about training on tailoring for women at Para centers.

Table-8: Suggestions for improvements

	Male	Female	All
	%	%	%
No suggestion	23.41	26.24	24.82
School dress for children	18.24	19.18	18.71
Snacks for children	16.82	16.71	16.76
Fresh water for children in Para Center	12.82	11.88	12.35
More healthcare related information	7.06	6.12	6.59
Improve pre-school standard	5.65	4.82	5.24
Improved service to pregnant mothers	4.47	5.41	4.94
More educational materials for children	5.53	4.24	4.88
More games materials for children	3.41	5.06	4.24
Hygienic latrine at Para Center	3.65	2.82	3.24
Increased remuneration of Para Workers	2.94	3.06	3.00
Others	28.71	24.82	26.76
Cannot say	2.24	1.29	1.76
Base - All Respondents	850	850	1700

Table-9: Activities that could be provided by the Para Center that are not already provided

	Male	Female	All
	%	%	%
No suggestion	81.53	80.59	81.06
Establish tailoring training for women	2.24	2.82	2.53
Served pregnant women at home	1.53	2.82	2.18
Others	11.41	10.00	10.71
Cannot say	4.47	4.94	4.71
Base - All Respondents	850	850	1,700

Opinion about continuation of Para center activities: Everybody gave affirmative response to the question if Para center activities should continue. The main reason for such opinion was that it 'Provides opportunity to educate children' mentioned by about 90% of the respondents. The other major reasons were that it makes the community aware about health and nutrition related matters.

Graph-9: Opinion about continuation of Para center activities

Figure in %

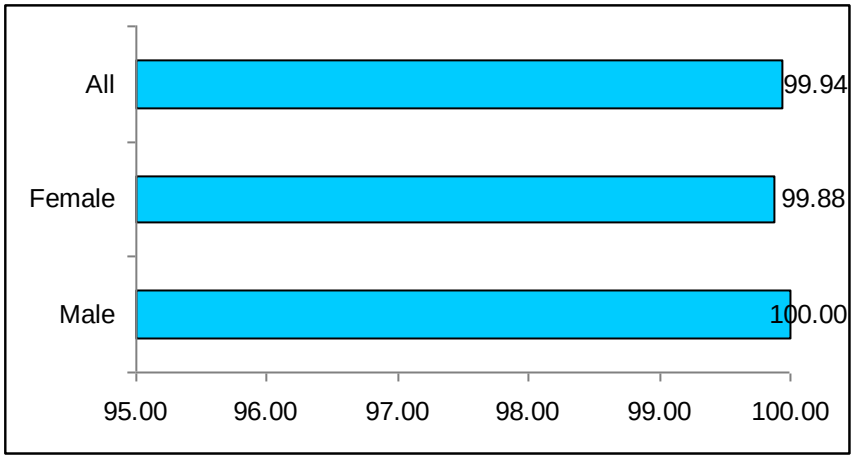


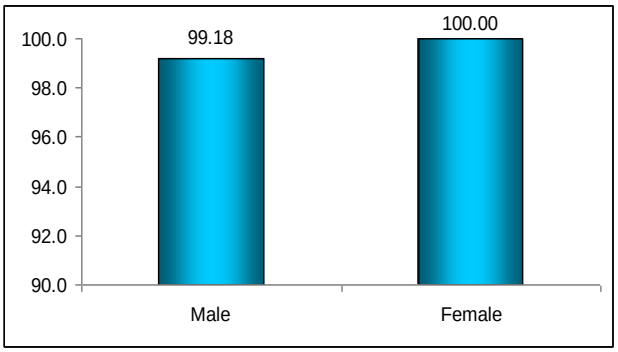
Table-10: Reasons for continuing Para center activities

	Male	Female	All
	%	%	%
Provides educational opportunity to children	87.88	88.22	88.05
Make community aware of healthcare	27.88	29.92	28.90
Make community aware of nutrition	9.88	8.83	9.36
Advice and healthcare services for pregnant women	4.24	4.24	4.24
Make community aware of cleanliness/hygiene	3.76	3.89	3.83
Others	9.76	12.01	10.89
Base - Those supports to continue para center operation	850	849	1,699

Courtyard Meeting:

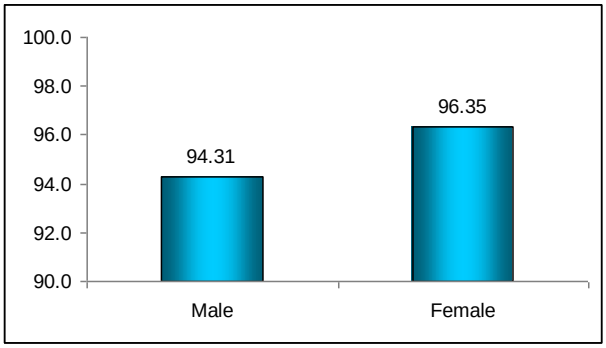
All females mentioned that courtyard meeting is held in their respective Paras, and almost all males verified the same. About 96% females reported to have attended such meetings in the last six months, which was also testified by the males. On average females attended these meetings 4.50 times in the last six months, and on average 2.60 times discussion was held specifically on nutrition. Almost all attending women (99%) stated that the Para workers discussed about iodized salt, and almost equal number of males also verified this. Most discussed point was 'Iodized salt prevents thyroid enlargement' mentioned by about 70% of the attendees. Other major points discussed were 'Iodized salt helps children's physical and mental development', 'Increases body immunity' and 'Advised to take iodized salt'. Almost all (98%) mentioned that the Para worker also discussed other nutritional issues, and the most mentioned issue discussed was about 'taking more green vegetables' mentioned by 70% attendees. Other mentionable ones were 'benefits of taking milk, egg and fruits'.

Graph-10: Incidence ever holding courtyard meeting

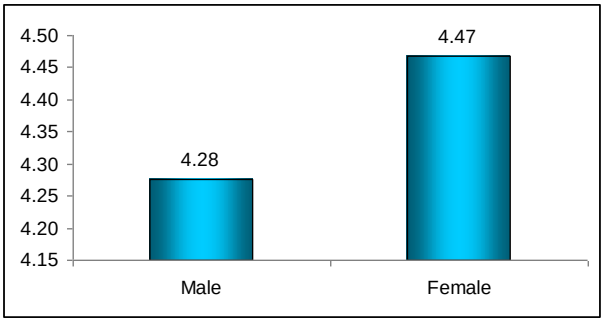


Graph-11: Incidence holding courtyard meeting in last 6 months

Figure in %

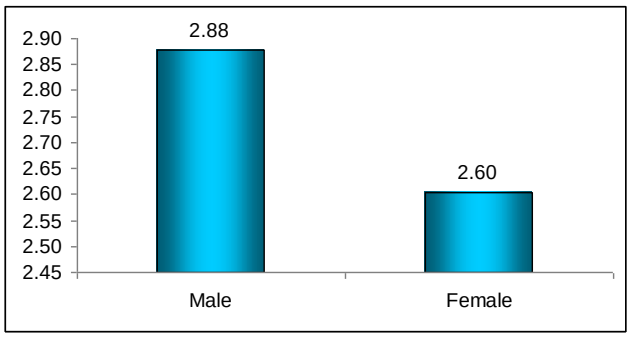


Graph-12: Number of courtyard session attended



Graph-13: Number of courtyard meeting specifically discussed about Nutrition

Figure in %



Graph-14: Incidence of Para worker talking about salt iodized salt

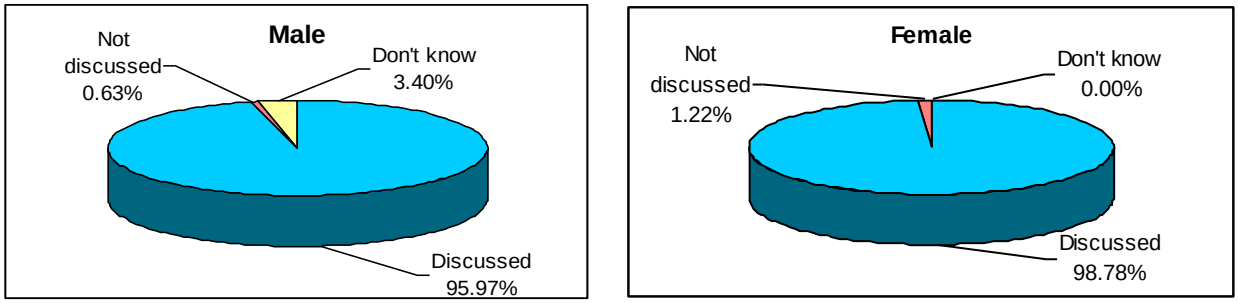


Table-11: Issues discussed about iodized salt

	%
Taking iodized salt prevents thyroid enlargement/ due to scarcity of iodine in body thyroid enlargement occurs	69.59
By taking iodized salt children's physical and mental development	17.31
Taking iodized salt, body immunity increases	11.74
Had advised to take iodized salt	10.38
Night blindness can happen due to lack of iodine	5.56
Due to scarcity of iodine, child can be mentally retarded	3.09
Explained how to test iodine in salt	2.47
Iodine's medicinal value gets lost if kept opened	0.25
Don't remember	3.96
Base - Those attended courtyard meeting (Female)	809

Graph-15: Incidence of Para worker discussing other nutrition related issues

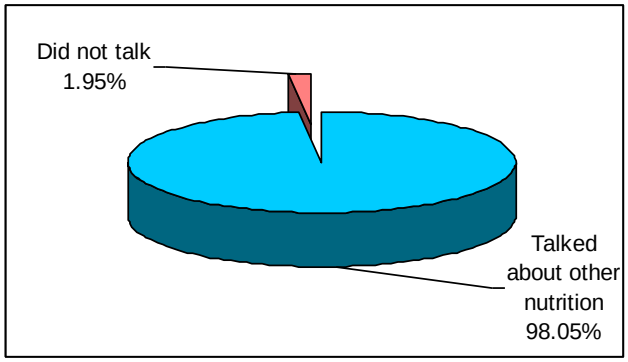


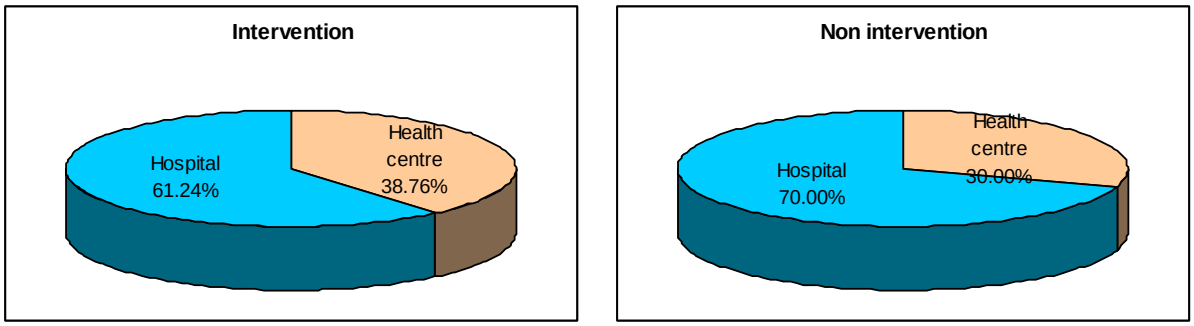
Table-12: Other Nutrition issues discussed

	Intervention
	%
Advised to take more green vegetables	70.24
Explained benefits & advised taking of milk and egg	14.82
Advised to take fruits	12.70
Advised to take small fish	9.22
Talked about vitamin 'A' & its source	7.47
Explained benefits & advised taking of fish and meat	5.23
Children advised to take foods containing vitamin	3.99
Pregnant women advised to take Red amaranth	3.61
Asked to take mineral powder	3.24
Kachu saak' and Red amaranth improves eye sight	3.24
Others	9.71
Can't remember	7.35
Base - Those lessoned nutrition related issue(Female)	803

Nearest Health Facility:

Type of nearest healthcare facility: In both intervention and non-intervention area the nearest healthcare facility was Hospital, mentioned by 61% and 70% respondents respectively. The other facility was Health Center (39% and 30% respectively). However, it can be observed that Health Center as nearest healthcare facility was more prevalent in intervention area than in non-intervention area.

Graph-16: Type of nearest health facility



Services available in nearest health facility: Services available in health centers and hospitals appear common, with varying degrees though. Most mentioned services available in some order were treatment of general diseases, diarrhea, malaria, antenatal care, vitamin- A capsule, family Planning, TT Vaccine, delivery, pneumonia treatment, adolescent health care and tuberculosis treatment. However, it was noticed that antenatal care and delivery were mentioned significantly higher for health center in intervention area than in non-intervention area.

Table-13: Health facilities available in nearest health facility

	Intervention		Non intervention	
	Health centre	Hospital	Health centre	Hospital
	%	%	%	%
General Diseases	98.9	97.9	86.3	96.6
Diarrhoea	81.9	88.7	86.9	84.6
Malaria	50.4	82.5	52.3	82.4
Antenatal Care	65.3	61.6	25.5	50.7
Vitamin- A capsule	51.0	51.5	54.9	30.8
Family Planning	44.0	36.2	35.9	27.2
TT Vaccine	32.5	37.8	30.7	29.1
Delivery	32.6	35.6	5.9	30.3
Pneumonia	16.2	39.4	41.8	26.6
Adolescent Health Care	15.5	20.7	10.5	10.1
Tuberculosis	10.0	19.4	11.1	18.2
Kala-a-Zar)	7.6	15.5	30.7	10.4
Primary Eye Care)	15.8	13.8	0.0	12.0
E P I)	10.3	13.7	12.4	14.3
Others	3.8	13.0	3.9	10.1
Don't Know	0.5	0.0	0.0	0.0
Base- All Respondents	659	1,041	153	357

Health facility visiting habits & services received: Around 90% of respondents reported to be visiting their respective nearest health center or hospital for healthcare services in both areas. Among those who visit the nearest health facility, majority visited once or twice in the last 6 months, while 18 – 40% did not visit at all. Most people visited for treatment of general disease. Other mentionable causes were treatment diarrhea and malaria.

Among persons visiting their respective nearest health facility, everybody found doctor in the hospitals, as against 42% and 37% in health centers in intervention and non-intervention areas respectively. Those who did not find doctor in their nearest respective health facility mentioned that average distance to health facility where doctor is available varies between 7 and 13 km, and takes between 50 and 70 minutes to reach.

Graph-17: Incidence of visiting nearest health facility

Figure in %

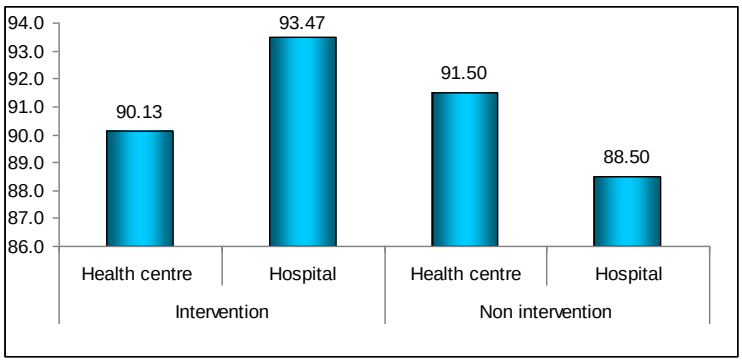


Table-14: Number of times visited health facility for service in last six months

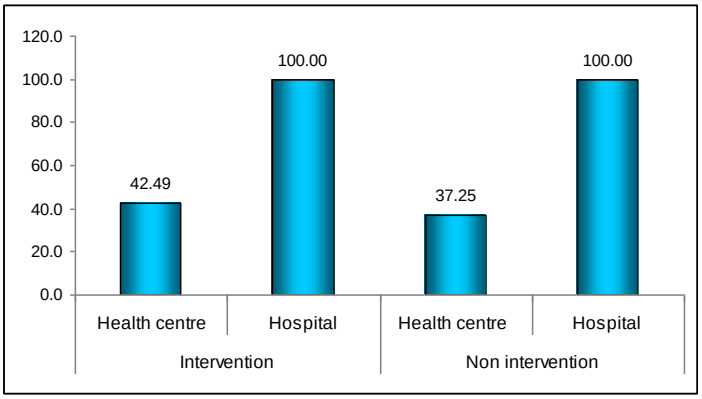
	Intervention		Non intervention	
	Health centre	Hospital	Health centre	Hospital
	%	%	%	%
Once	37.0	33.0	32.1	34.2
Twice	22.6	22.9	28.6	16.5
Thrice	8.9	7.5	14.3	7.9
More than thrice	5.2	4.9	7.1	1.3
Not visited	26.3	31.7	17.9	40.2
Base - Those visited health center in last 6 months	594	973	140	316

Table-15: Health service in the last occasion

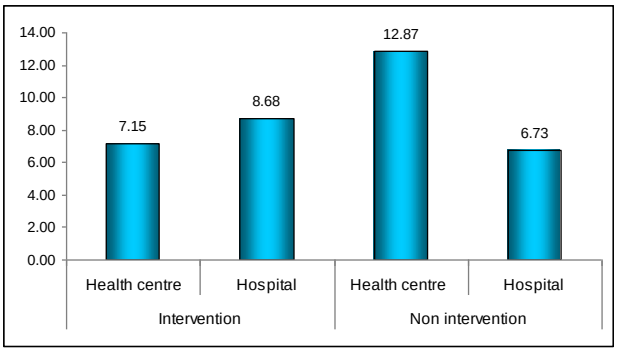
	Intervention		Non intervention	
	Health centre	Hospital	Health centre	Hospital
	%	%	%	%
General Diseases	76.3	73.0	62.9	62.7
Diarrhoea	13.5	10.7	25.7	19.9
Malaria	9.4	11.7	14.3	19.0
Family Planning	4.7	4.5	5.0	0.9
Kala-a-Zar	2.4	3.3	6.4	1.3
Vitamin- A capsule	3.0	3.0	5.7	1.3
Antenatal Care	2.2	2.2	1.4	0.9
TT vaccine	1.9	2.0	2.1	1.3
Others	7.7	8.1	10.7	8.2
Base - Those visited health center in last 6 months	594	973	140	316

Graph-18: Availability of doctor in nearest health facility

Figure in %



Graph-19: If doctor no available the distance of facility where doctor is available



Graph-20: Time it takes to reach the facility with doctor

Figure in %

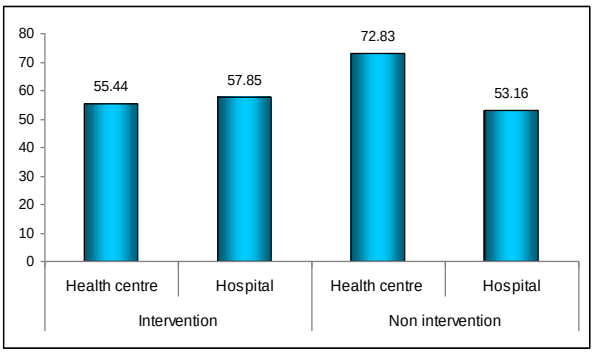
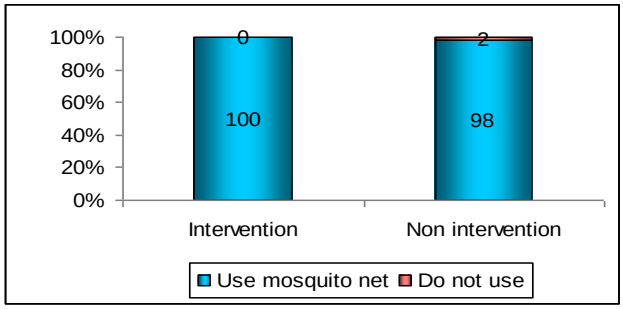


Table-16: Mode of Transport

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Motor vehicle and by walking	31.18	32.12	31.65	26.27	30.59	28.43
Walking	22.94	21.53	22.24	38.43	36.47	37.45
Motor Vehicle	25.41	25.53	25.47	24.31	21.96	23.14
Boat	7.53	7.65	7.59	5.49	5.10	5.29
By boat and by walking	3.65	3.29	3.47	1.96	1.96	1.96
By rickshaw and by walking	3.18	2.94	3.06	1.57	1.57	1.57
Rickshaw	2.47	2.82	2.65	1.57	1.96	1.76
Motor vehicle and by boat	2.12	2.35	2.24	0.39	0.00	0.20
Motor vehicle, by boat and by walking	0.94	0.82	0.88	0.00	0.39	0.20
Motor vehicle and by rickshaw	0.47	0.82	0.65	0.00	0.00	0.00
Base - All Respondents	850	850	1700	255	255	510

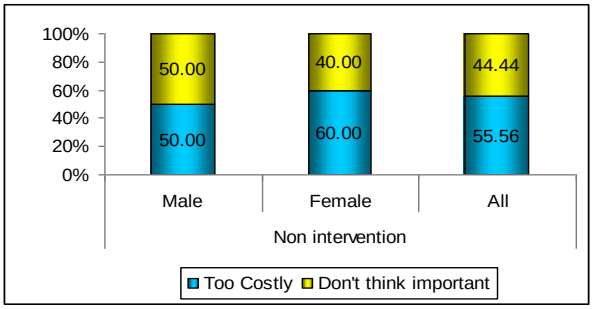
Usage of mosquito net: Almost all households in both intervention and non-intervention areas use mosquito net for sleeping. Only 2% in non-intervention area do not use it, either because it is expensive or did not feel the necessity. Only about 15% of nets had holes in them in both areas as was observed by the enumerators. On average a mosquito net owning household in intervention area claimed to have three nets, as against which in non-intervention area it is two and half. Almost all members of a family with mosquito net sleep inside net. Only a few don't mainly due to lack of space inside net.

Graph-21: Incidence of using mosquito nets

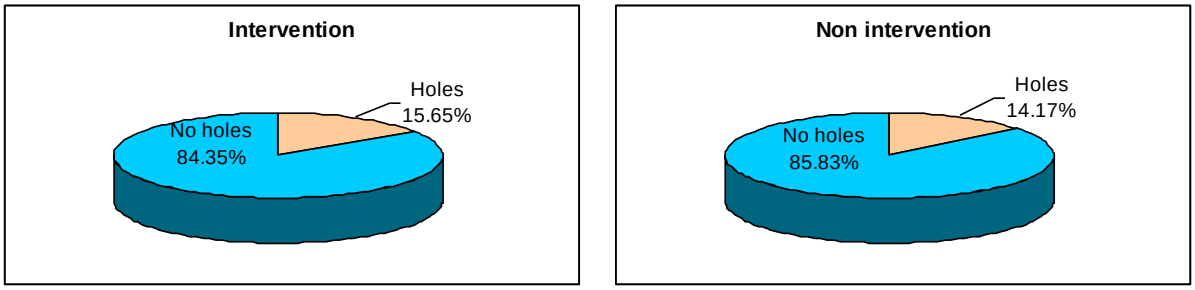


Graph-22: Reasons for not using mosquito net

Figure in %

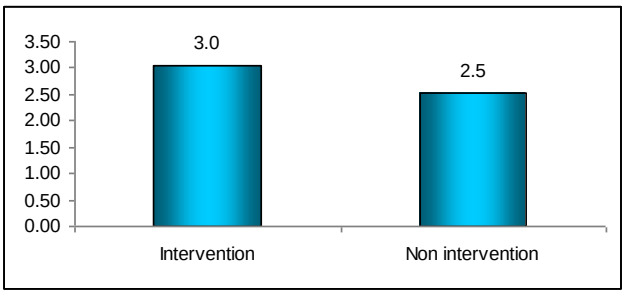


Graph-23 : Incidence of holes in mosquito net

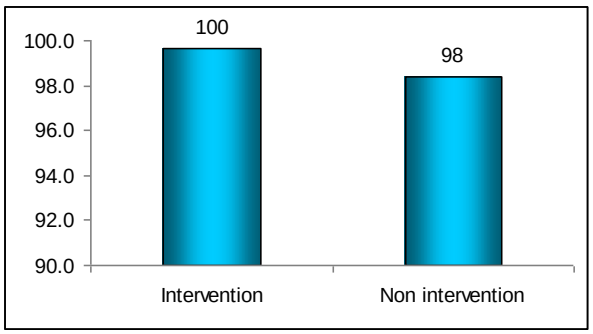


Graph-24: Average number of mosquito nets per household

Figure in %

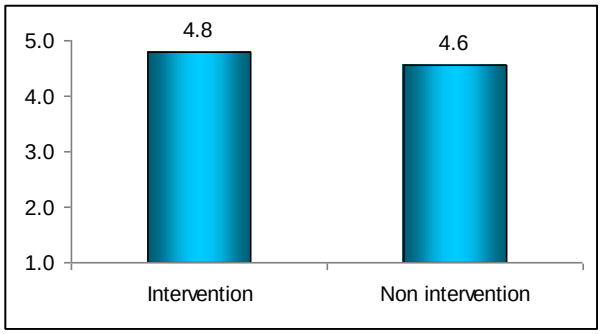


Graph-25: If everybody in family sleep under the nets



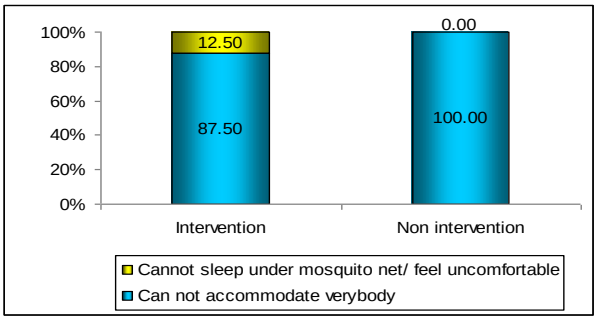
Graph-26: Average number of persons who sleep under nets per family

Figure in %



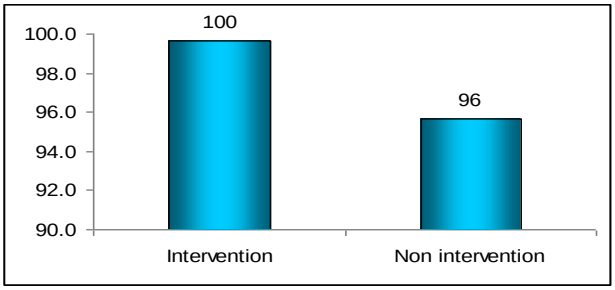
Graph-27: Reasons if everybody doesn't sleep under net

Figure in %



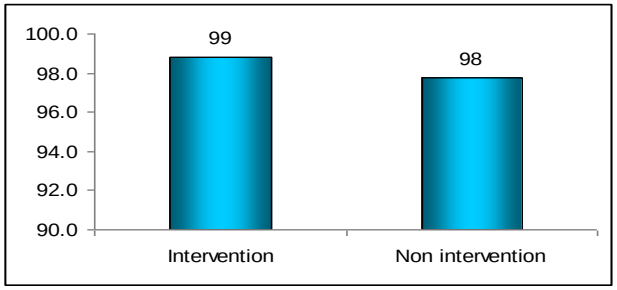
Consumption of iodized salt: All households in intervention area consume iodized salt against 94% in non-intervention area. Salt was tested by the enumerators and mostly (more than 98%) found to contain iodine.

Graph-28: Incidence of consuming iodized salt



Graph-29: Verified iodized salt

Figure in %



Water and Sanitation:

Sources of water: Tube-well was most common source of for both drinking and bathing irrespective of area. Other major sources were water flow (spring)/canal, lake, well, pond, etc. However, while for drinking people of non-intervention area claimed to use tube well water more than that of intervention area, for bathing it was other way round, as can be seen from the following tables.

Table-17: Source of collecting water for drinking

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Tube well	51.65	54.00	52.82	57.65	60.39	59.02
Water flow/canal	17.65	16.12	16.88	9.41	11.37	10.39
Well	3.76	4.35	4.06	21.18	17.65	19.41
Lake	10.71	9.65	10.18	6.27	4.71	5.49
Waterfall	7.65	7.29	7.47	0.78	0.78	0.78
Pond	6.00	7.18	6.59	0.78	0.78	0.78
Pipe lined	3.06	2.82	2.94	5.10	5.49	5.29
River	1.65	1.76	1.71	5.10	6.67	5.88
Reserved Rain water	0.59	0.59	0.59	2.35	1.96	2.16
Base - All Respondents	850	850	1700	255	255	510

Table-18: Source of collecting water for bathing

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Tube well	50.2	52.7	51.5	35.29	36.08	35.69
Water flow/canal	11.3	10.6	10.9	13.33	14.12	13.73
Lake	7.6	8.5	8.1	13.33	12.55	12.94
Waterfall	7.9	7.8	7.8	6.67	8.63	7.65
Pond	19.1	18.8	18.9	7.45	7.45	7.45
Well	3.8	3.3	3.5	13.73	11.37	12.55
Pipe lined	2.4	2.4	2.4	5.49	6.67	6.08
River	1.8	1.2	1.5	7.45	8.24	7.84
Reserved Rain water	0.7	0.4	0.5	1.96	0.78	1.37
Base - All Respondents	850	850	1,700	255	255	510

Sanitation and hygiene: Incidence of having latrine at home was higher in intervention than in non-intervention area. In intervention area 91% households claimed to have latrine of their own as against 82% in non-intervention area. Most common types of latrine were slab without seal and pit with cover in both areas, followed by slab with seal in intervention area and open/hanging in non-intervention area. However, incidence of slab with seal was higher in intervention area (25%) than in non-intervention area (12%).

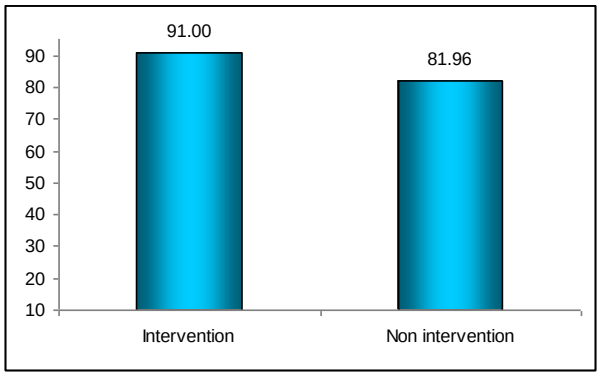
In intervention area 92% latrines were observed by the enumerators as against 69% in non-intervention area. Out of the observed latrines, 80% and 77% respectively were found clean. Soap was available around 73% and 57% observed latrines respectively, and ash in 10% and 13%. Neither soap nor ash was available in 17% and 30% latrine respectively. Water container was available in 71% and 37% of the observed latrines, and of the available containers 95% and 93% contained water in intervention and non-intervention areas respectively. These all indicate much better hygiene practice in intervention area.

In both areas about half of the respondents stated that it's the responsibility of all family members to maintain the latrine, about one third mentioned about housewife and 13% mentioned house head. Bringing water also follows the same pattern. This indicates that housewife is the single most responsible person for maintaining latrine and bringing water, followed distantly by the house head.

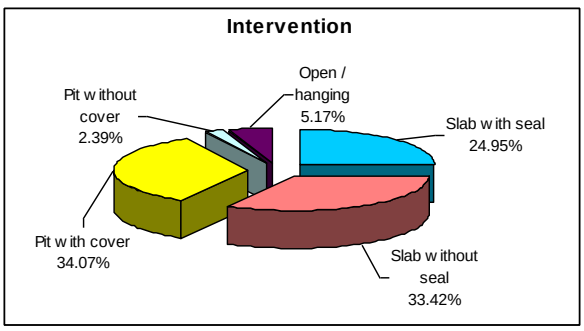
After defecation, little more than 80% respondents in intervention area claimed to use soap for washing hand irrespective of gender, as against little above 50% in non-intervention area, followed by water only (14% and 33% respectively). Most of the rest use ash (more in non-intervention area). These also reveal better hygiene practice in intervention area.

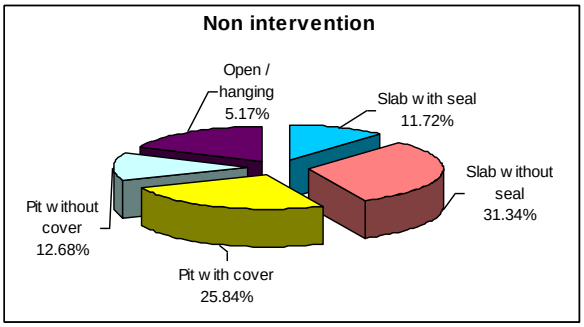
Graph-30: Incidence of ownership of household latrine

Figure in %



Graph-31: Type of latrine owned

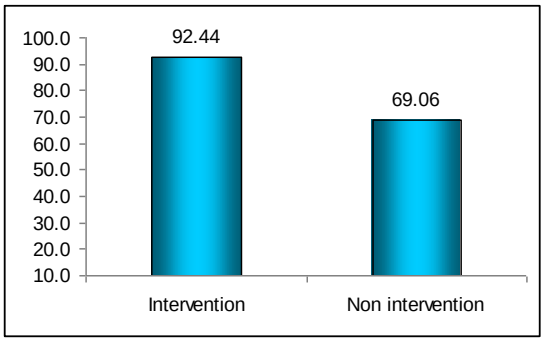


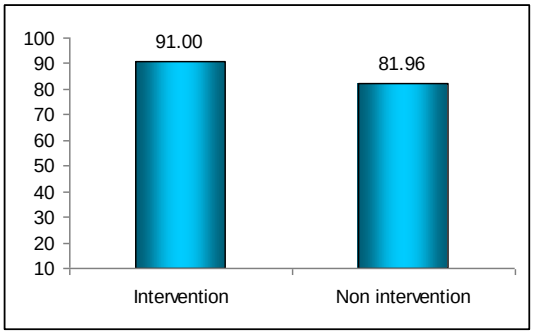


Graph-32: Percentage of latrine area visited by enumerator

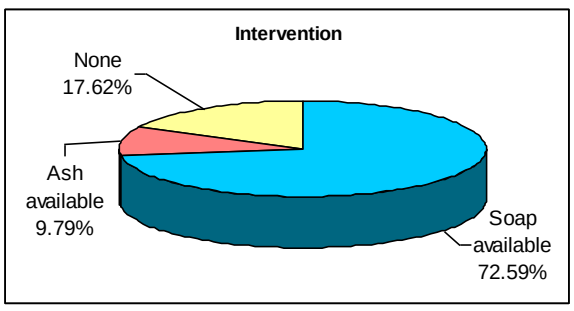
Graph-33: Percentage of visited latrine area found clean

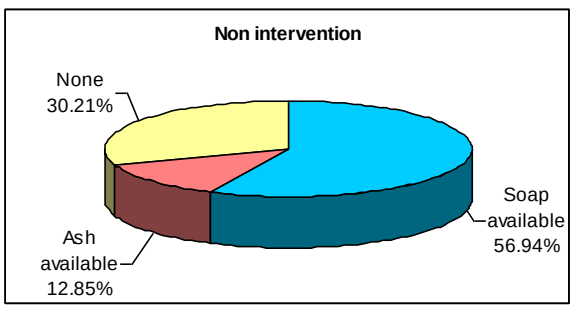
Figure in %



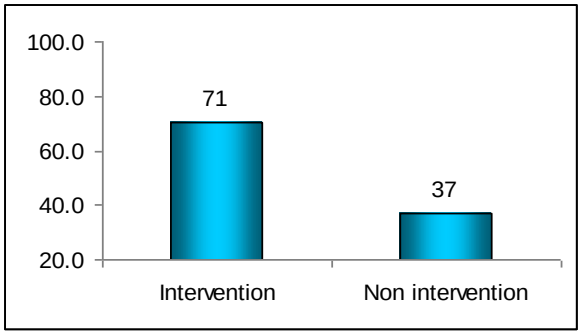


Graph-34: Availability of soap/ash



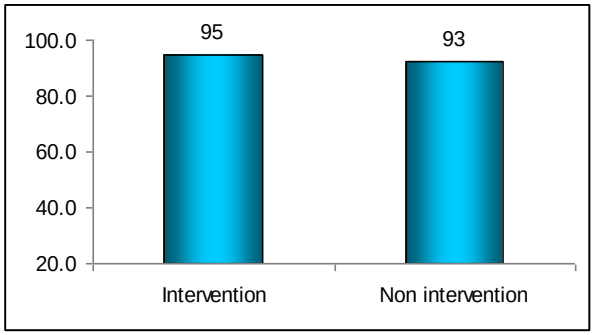


Graph-35: Availability of water container

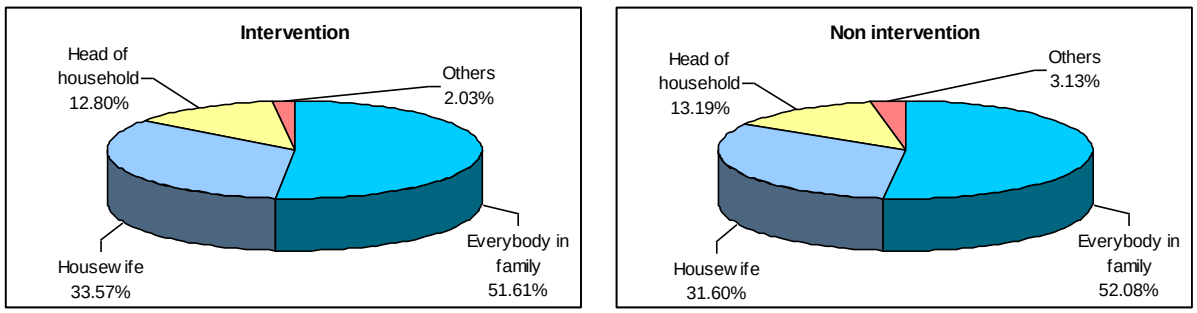


Graph-36: Availability of water in container

Figure in %



Graph-37: Person responsible for maintaining latrine in family



Graph-38: Person responsible for bringing water

Figure in %

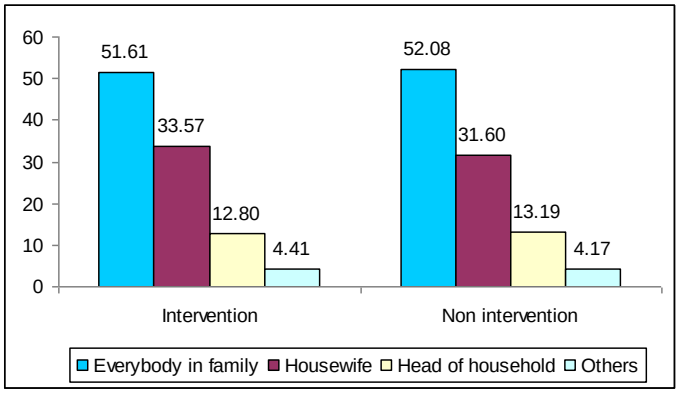
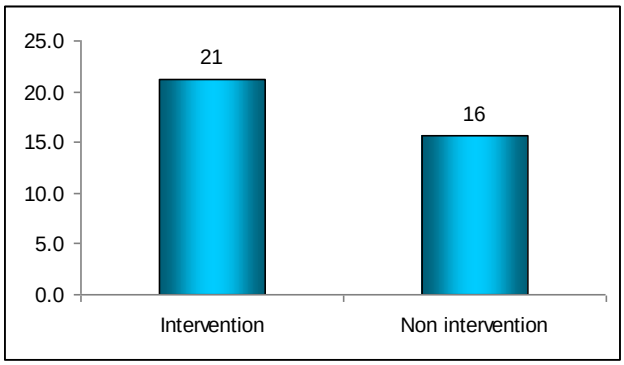


Table-19: Post defecation cleanliness

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Use Soap	80.4	82.8	81.6	52.4	55.2	53.8
Ash	4.2	3.5	3.9	10.6	9.0	9.8
Water Only	15.1	13.4	14.3	34.1	31.0	32.5
None	0.3	0.3	0.3	2.9	4.8	3.8
Base - Those have latrine at home	779	768	1,547	208	210	418

Graph-39: Incidence of sharing latrine facility with other households

Figure in %



Latrine procurement sources of motivation & training: For purchasing/setting up latrine, Para worker (42%) was the most mentioned source of motivation in intervention areas, followed by self/family (26%) and NGO/Health Worker (19%). Training on how to use a latrine was also imparted most by the Para worker (70%). Other mentionable sources were NGO/Health Worker (12%) and Local school teacher (115).

Table-20: Drivers of motivation in purchasing of latrine

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Para Worker	42.16	50.42	46.29	0.00	0.00	0.00
Self initiative/ family members	25.77	22.21	23.99	23.94	26.03	25.00
NGO Worker/ Health Worker	18.77	12.57	15.66	35.92	34.25	35.07
Inspired by seeing neighbor's latrine	8.26	10.34	9.30	26.06	24.66	25.35
Chairman of Union Parishad/ Member	6.58	6.56	6.57	3.52	6.85	5.21
Seeing television	4.20	2.79	3.50	4.93	3.42	4.17
Others	1.26	0.98	1.12	7.04	4.79	5.90
Base-Those have inspected latrine	714	716	1430	142	146	288

Table-21: Source of learning how to use latrine

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
From Para Worker	66.25	73.46	69.86	0.00	0.00	0.00
NGO Worker/ Health Worker	15.83	8.66	12.24	39.44	37.67	38.54
From local school teacher	12.32	8.80	10.56	22.54	20.55	21.53
From family members	4.06	6.01	5.03	17.61	22.60	20.14
Chairman of Union Parishad/ Member	6.16	4.61	5.38	14.08	13.70	13.89
Others	1.12	1.12	1.12	5.63	4.11	4.86
Base-Those have inspected latrine	714	716	1430	142	146	288

Micro Credit:

There appears no major difference in the area of micro finance between intervention and non-intervention areas. As a whole, 27% and 30% households in intervention and non-intervention areas borrowed money from micro finance agencies respectively. Major sources of borrowings were Grameen Bank, BRDB, IDF, BRAC, Bridge and ASA. In intervention area only about 5% (4% in non-intervention area) took micro credit offered by BRDB, of which three-fourths received by females, and the rest received either by males or jointly. Average amount of loan received was BDT12500.00 (rounded) in intervention area and BDT14100 (rounded) in non-intervention area. Almost all recipients mentioned that their income has increased after receiving micro credit.

Graph-40: Incidence of taking loans from any micro credit schemes

Figure in %

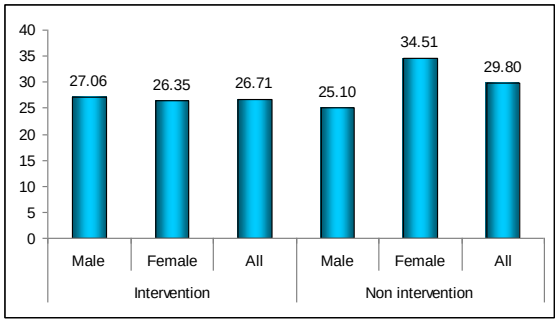


Table-22: Source of micro-credit:

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Grameen Bank	21.74	28.13	24.89	32.81	37.50	35.53
BRDB	16.09	19.20	17.62	12.50	12.50	12.50
IDF	14.35	12.95	13.66	15.63	21.59	19.08
BRAC	11.30	14.73	13.00	18.75	15.91	17.11
Bridge	18.26	9.38	13.88	9.38	3.41	5.92
ASA	9.57	9.38	9.47	7.81	15.91	12.50
Padokshep	3.91	2.23	3.08	6.25	0.00	2.63
SAAJ	3.04	4.02	3.52	1.56	1.14	1.32
Others	7.39	6.70	7.05	4.69	5.68	5.26
Base – Those take loan	230	224	454	64	88	152

Graph-41: Incidence of ever receiving micro-credit offered through BRDB

Figure in %

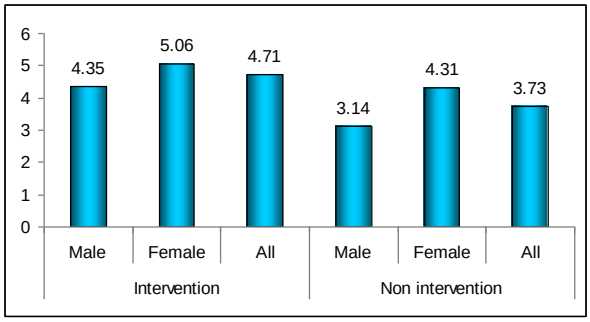


Table-23: Gender of person in the house who received the credit

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Male	29.7	9.3	18.8	75.0	36.4	52.6
Female	67.6	79.1	73.8	25.0	54.5	42.1
Jointly	2.7	11.6	7.5	0.0	9.1	5.3
Base - Those received funds from BRDB	37	43	80	8	11	19

Table-24: Amount of credit received from BRDB

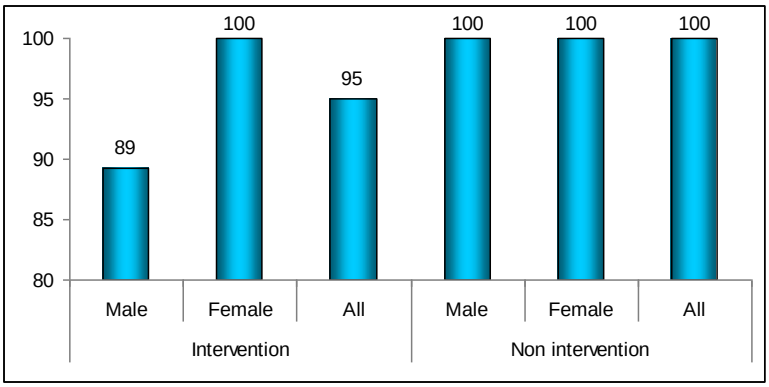
	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Up to taka 5000	16.2	14.0	15.0	12.5	27.3	21.1
Taka 5001-10000	32.4	48.8	41.3	25.0	27.3	26.3
Taka 10001-15000	18.9	16.3	17.5	0.0	18.2	10.5
Taka 15001-20000	18.9	16.3	17.5	50.0	18.2	31.6
More than taka 20000	13.5	4.7	8.8	12.5	9.1	10.5
Average	14,000.00	11,197.67	12,493.75	15,750.00	12,909.09	14,105.26
Base - Those received	37	43	80	8	11	19

Table-25: Field of utilizing credit

	Intervention			Non intervention		
	Male	Female	All	Male	Female	All
	%	%	%	%	%	%
Agriculture/ Jhum cultivation	40.5	39.5	40.0	87.5	54.5	68.4
Small business	37.8	37.2	37.5	0.0	0.0	0.0
Buying cattle and rearing same	13.5	18.6	16.3	12.5	18.2	15.8
Repairing of houses	0.0	11.6	6.3	12.5	18.2	15.8
Others	8.1	4.7	6.3	0.0	18.2	10.5
Base - Those received credit	37	43	80	8	11	19

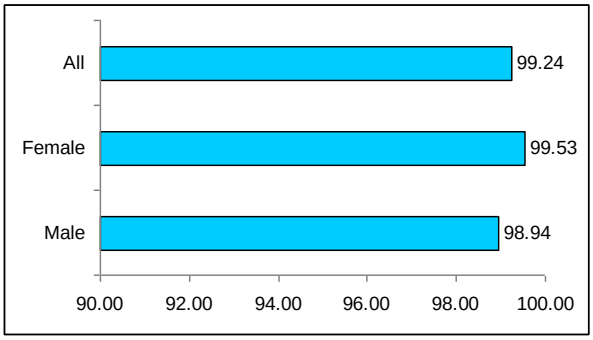
Graph-42: If average family income increased after receiving micro-credit

Figure in %



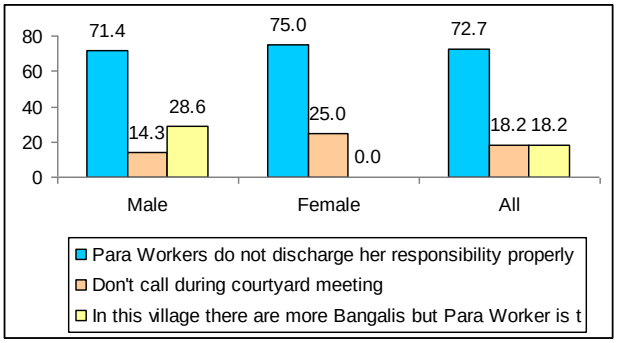
Selection and remuneration of Para worker: Almost everybody thought that selection of Para worker was appropriate. However, in response to question whether in future community people will voluntarily contribute to raise fund for paying wages to Para worker, only about a third responded affirmatively, indicating that outside fund will be required to make their salary going.

Graph-43: Percentage of respondents opining that selection of Para Worker was appropriate



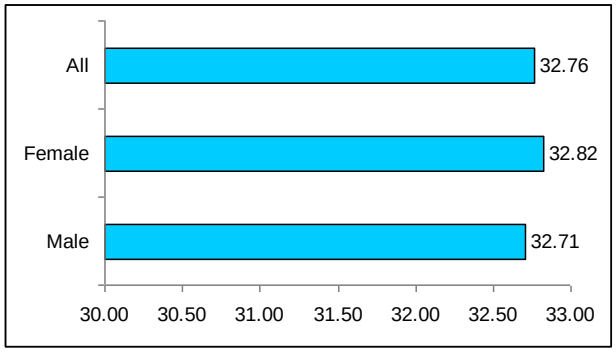
Graph-44: Reasons, if no

Figure in %



Graph-45: Percentage of respondents opining that in future community would be willing to pay wages of Para Workers

Figure in %



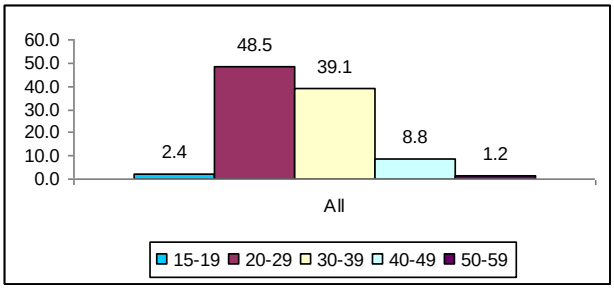
5. PARA CENTER SURVEY:

Profile of Para Workers:

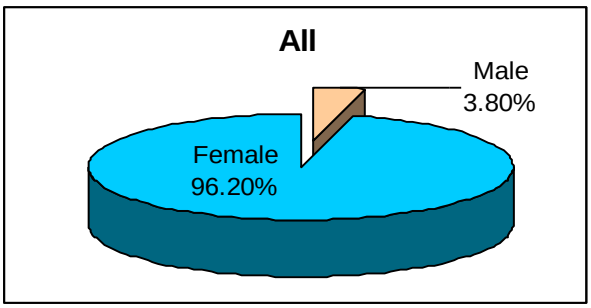
About half of the Para workers were young and less than 30 years of age and of about 40% were below 40 years. Most of them were females (96%), and only 4% males. Mostly married (80%), 16% were unmarried, and the rest 4% were either widowed or divorced. It appears most females were widowed. An overwhelming majority (80%) were Buddhists, followed far behind by Muslims (16%). Ethnicity wise Chakma and Marma made up 37% and 36% respectively, followed by Bangalis (17%). Others make up the rest. District-wise, however, there are variations as shown in table below. All Para Workers had attended school, and about half of them (47%) studied up to Class/Standard VIII/IX, 45% passed SSC and the remaining 7% were graduates or above.

Graph-46: Age

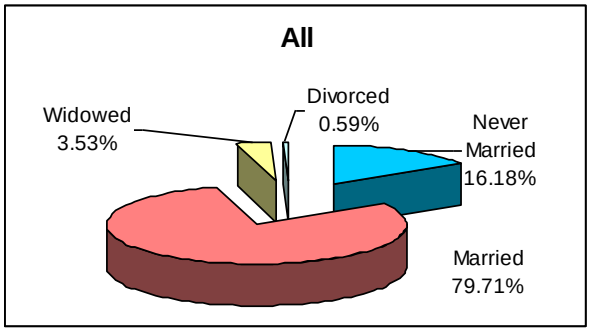
Figure in %



Graph-47: Sex



Graph-48: Marital status



Graph-49: Religion

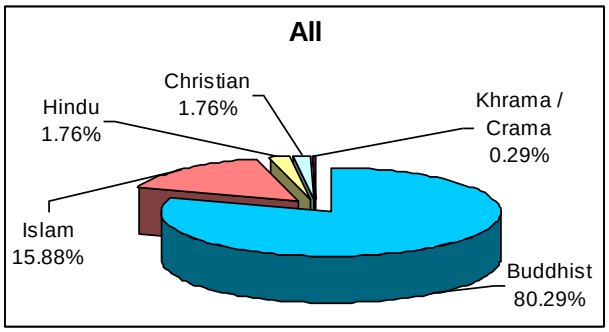
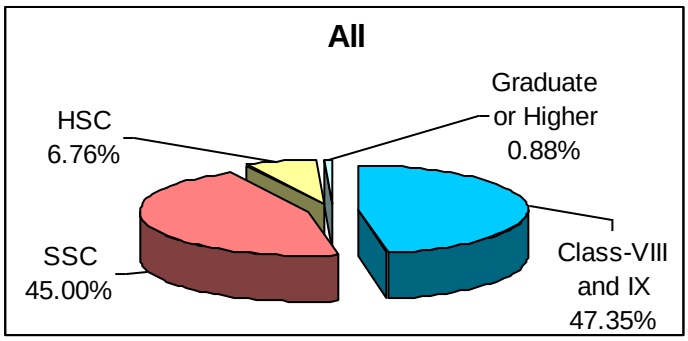


Table-26: Ethnicity

	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
Chakma	6.7	34.9	59.8	36.5
Marma	67.4	37.2	11.5	35.9
Tripura	4.5	0.0	4.1	2.6
Bangali	3.4	19.4	24.6	17.1
Tenchungya	13.5	8.5	0.0	6.8
Khyang	2.2	0.0	0.0	0.6
Murong/ Mro/ Mru	1.1	0.0	0.0	0.3
Bowm	1.1	0.0	0.0	0.3

Base-All Respondent	89	129	122	340

Graph-50: Highest grade/class completed



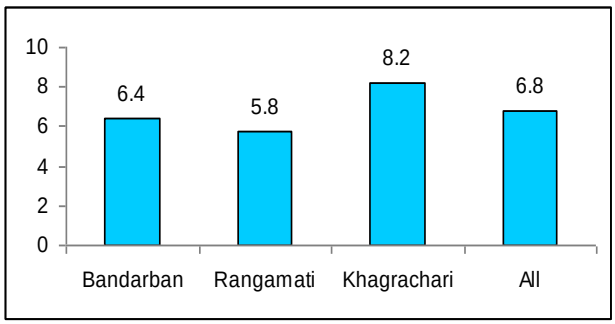
Recruitment/Employment and Training:

Para workers were found employed on average for 7 years. However, many of them (about one – third) have been working for more than 10 years. Although salaries are very low, almost all of them have been receiving salary on time. The other motivation was that becoming Para worker appeared to have changed their life a bit mainly through marginal improvement in financial condition, gaining knowledge on related matters and earning respect of the community.

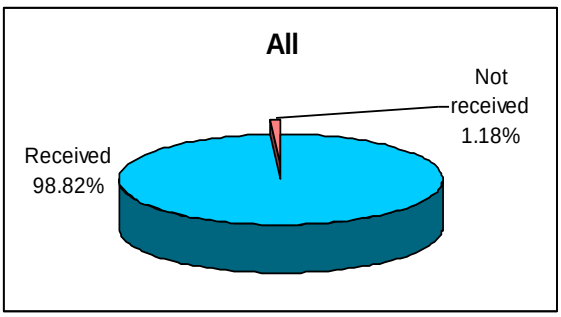
Almost everybody sat for test during recruitment, and most of whom (90%) sat for both written test and viva voce, the rest either took written or oral test. In Rangamati and Khagrachhari most of the workers (90 – 100%) reported to have received training on health, nutrition and community related areas. Whereas in Bandarban the situation does not appear as good, especially with regard to training on infectious diseases, worm infestations, water-born diseases, family planning and prevention of maternal and infant death as revealed from the table below.

Graph-51: Years as Para Worker

Figure in %

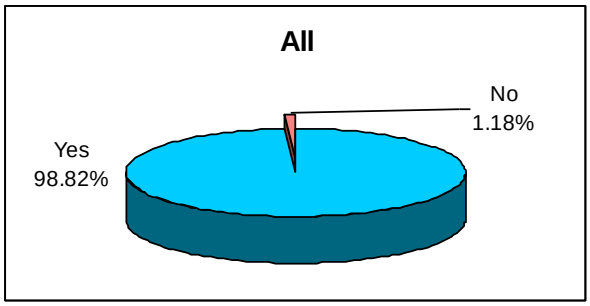


Graph-52: Incidence of receiving salary on time



Graph-53: Recruited exam taken

Graph-54: Type of exam taken



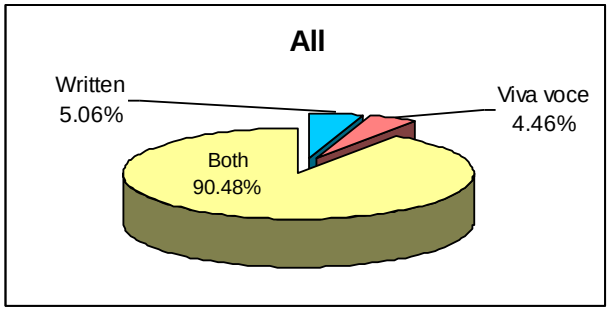


Table-27: Training programs attended

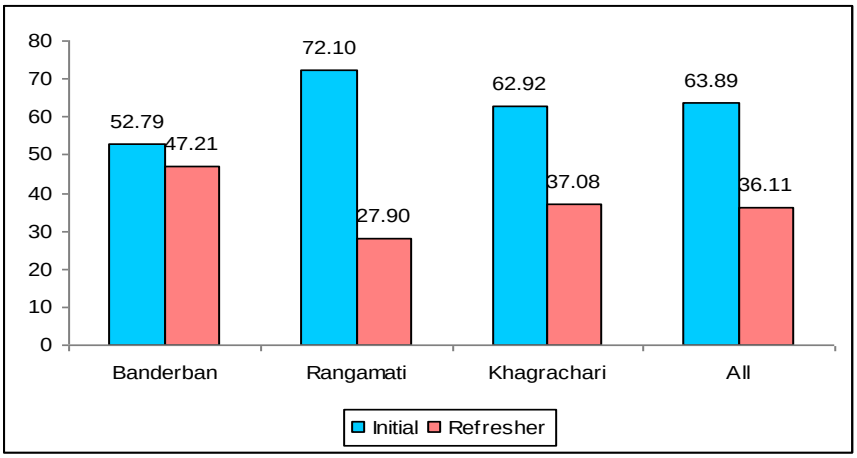
	Banderban	Rangamati	Khagrachari	Total
	%	%	%	%
ECD-Early Child Development	97.8	93.0	85.2	91.5
Health Related	75.3	59.7	38.5	56.2
Health & Nutrition	0.0	28.7	41.8	25.9
Basic Training	10.1	21.7	34.4	23.2
MWTL (Multiple way's of Teaching and Learning)	4.5	17.1	37.7	21.2
Vitamin & Vaccination	12.4	13.2	23.8	16.8
Nutrition related	18.0	10.1	16.4	14.4
ARI-Acute Respiratory Infections	0.0	4.7	24.6	10.6
Iron	7.9	13.2	5.7	9.1
SHWEA-B-Sanitation, Hygiene Education and Water Supply in Bangladesh	13.5	8.5	3.3	7.9
Others	19.1	10.9	8.2	12.1
Base - All Respondents	89	129	122	340

Table-28: Duration of training

Day	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
1-3 days	14.16	22.93	23.53	21.10
4-6	21.03	8.29	13.55	13.39
7-9 days	13.30	15.19	20.20	16.73
10-12 days	24.46	15.47	8.18	14.71
13-15 days	14.59	26.80	20.72	21.50
More than 15 days	12.45	11.33	13.81	12.58
Average	9.96	10.05	9.61	9.85
Base-Those received training (N)	233	362	391	986

Graph-55: Type of training

Figure in %


80
70
60
50
40
30
20
10
0
52.79
47.21
72.10
27.90
62.92
37.08
63.89
36.11
Banderban
Rangamati
Khagrachari
All
Initial
Refresher

Graph-56: If life changed since became a Para Worker

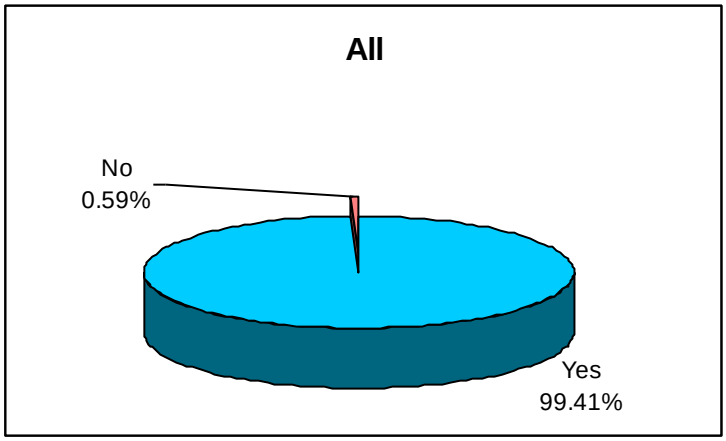


Table-29: Change in life experienced

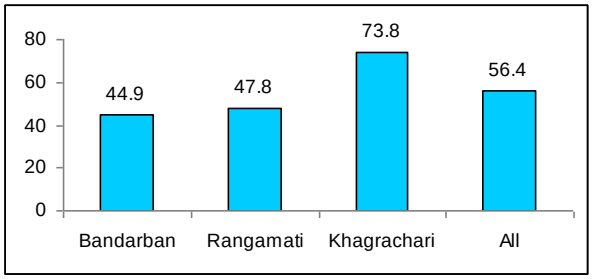
	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
Economic condition has improved to some extent/ economic condition has improved	47.7	54.3	52.9	52.1
Able to express views openly in front of other people	3.4	0.0	0.8	1.2
Known about many unknown matters related to health/ became much aware about health	15.9	14.0	23.1	17.8
Para community shows respect/ getting respect from Para Community	25.0	27.1	8.3	19.8
Others	8.0	4.7	14.9	9.2
Base-Those experienced change in life after became a Para Worker	88	129	121	338

Para Population and Services Rendered to them by Para Center:

Para population: On average there were 56 households in each Para, highest being in Khagrachhari (75) and least in Bandarban (45). However, in some Para, especially in Khagrachhari it goes beyond 150 families. In each Para on average 213 people live with the same pattern as mentioned above between districts. More than 80% Para workers reported that they are able to cover all households in their respective Paras. As a whole, 42 families and 198 people were being covered by each Para worker on average. Only about 5% Paras had more than one Para center.

Services rendered: Most commonly rendered services were preschool classes and health & nutrition information. Other major services included W&S demonstrations (e.g. latrine installation), immunization information, demonstrations of safe water and hygiene, Para information centre, provision of micronutrient supplement, meeting venue, nutrition demonstration and skill development with varying degrees across districts.

Graph-57: Average number households in a Para



Graph-58: Average number of households covered

Figure in %

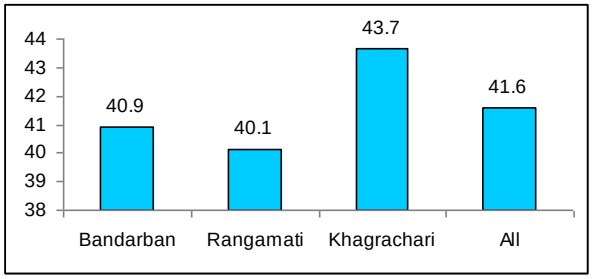
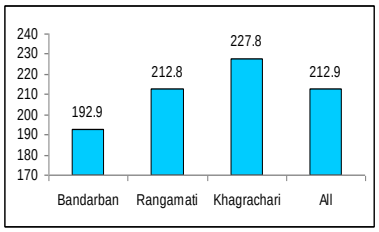


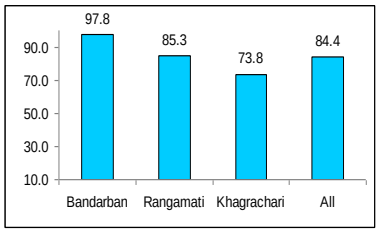
Table-30: Services rendered

	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
Preschool classes	100.00	98.45	96.72	98.24
Health & nutrition information	94.38	94.57	93.44	94.12
W&S demonstrations (e.g. latrine installation)	74.16	80.62	87.70	81.47
Immunization information	40.45	72.09	90.16	70.29
Demonstrations (safe water and hygiene)	53.93	54.26	88.52	66.47
Para information centre	29.21	36.43	69.67	46.47
Provision of micronutrient supplement	23.60	41.09	66.39	45.59
Meeting venue	25.84	24.81	74.59	42.94
Nutrition Demonstration	1.12	14.73	59.02	27.06
Skill development	2.25	3.88	55.74	22.06
Others	4.49	8.53	13.93	9.41
Base-All Respondent	89	129	122	340

Graph-59: Average number of people living in Para

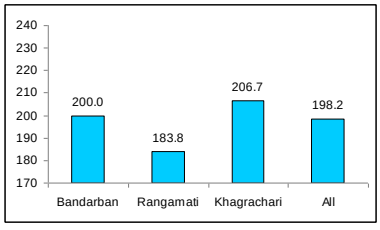


Graph-60: Able serve all



Graph-61: Average number covered all households not served

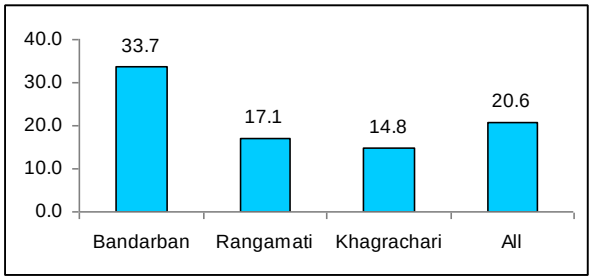
Figure in %



Micro Credit:

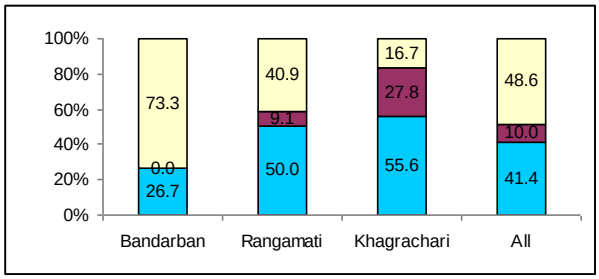
Only about one-fifth of Para workers mentioned to have micro credit component supported by ICDP/BRDB. Of them 41% make recommendation, 10 manage and the rest 49% reported to have no role in micro credit program; figures, however, varies by district. According to them on average 14 women and 20 men per Para received micro credit as stated by those who had some role in this regard. It appears that a loan recipient utilized the money for more than one purpose. Most utilization was for Agriculture/ Jhum Cultivation, utilized by 78%, followed by Cattle rearing (64%) and Small business. Some also used for fish culture (6%).

Graph-62: Incidence Micro Credit component supported by ICDP/BRDB

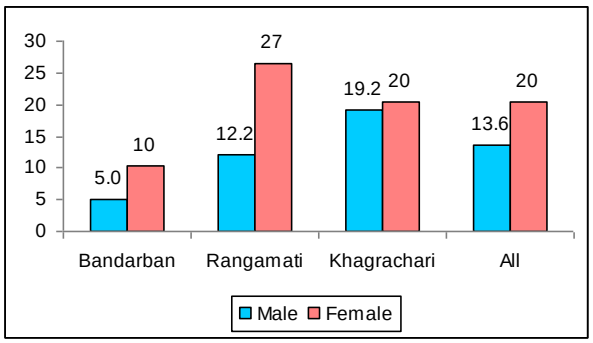


Graph-63: Role as a Para Worker

Figure in %

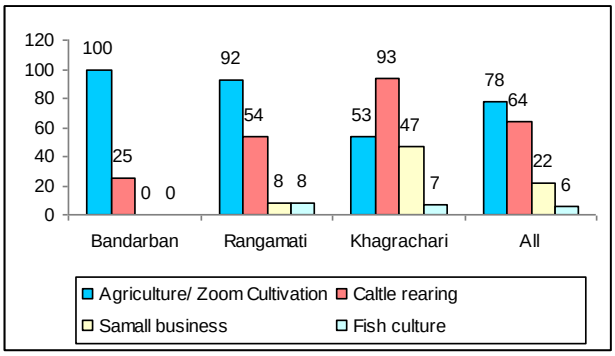


Graph-64: Persons received micro-credit in last five years



Graph-65: Area of utilization

Figure in %



Para Center – Infrastructure:

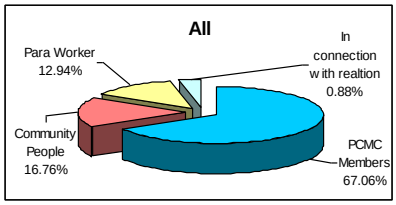
Only about 13% Para workers mentioned that it was their responsibility to repair Para center, and majority (67%) opined that the main responsibility lies with PCMC Members and Community People (17%). More than half of the Para workers opined that their respective centers require immediate repair. In most cases it would require wall repairing. Some would need roof, door, window and floor.

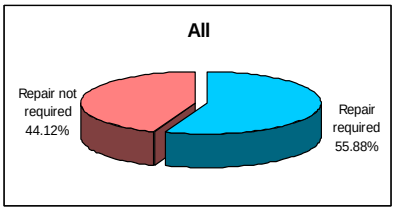
Graph-66: Person/body responsible for repairing Para Center

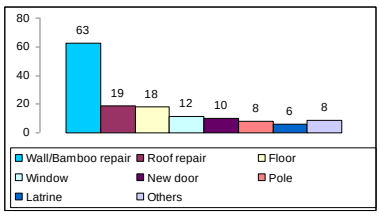
Graph-67: If repair required

Graph-68: Type of repair required

Figure in %







Community Information:

Display of information was found to be very high. Most of the community information/charts were displayed in 90% or more Para centers, and only Sanitarian Messages Chart, Schedule of Courtyard Meetings and Summary of Mosquito Net Use were displayed in less than 90% Paras (between 78% and 85%). However, most of the displayed information/charts were found legible, clear and up to date. Besides, in most cases (90% or more) Para Center Children attendance register, Review by Supervisor on last visit and Para Center Stock register were available with record date (as applicable) and up to date.

A similar scenario was also found in the last evaluation survey.

Table-31: Para center-community information

	All			
	Displayed	Legible	Clear	Up to date
	%	%	%	%
Para Village Map	95.3	95.3	95.3	95.3
List of PCMC Members	95.0	95.0	90.6	88.2
Schedule of Courtyard Meetings	84.4	90.0	87.6	85.0
Sanitarian Messages Chart	78.2	78.8	76.2	73.2
Summary of Immunization Levels	95.9	95.9	92.6	87.6
Summary of Hygienic Latrine Use	88.8	88.2	84.4	81.8
Summary of Mosquito Net Use	85.0	84.7	82.1	81.2
List of Children Aged Less than 2 years	92.1	92.6	90.0	87.1
List of Children Aged 3 to 5 years	95.3	96.2	93.8	90.9
List of Children Aged 5-6 years	92.9	93.2	91.2	87.9
List of Children who have graduated from Para Centre	89.7	88.8	85.6	83.8
List of Children who attend Primary School	93.2	92.1	88.5	87.9
List of Women aged between 14 and 49	98.5	97.6	93.8	90.9
List of Women Currently Pregnant	97.6	97.6	94.7	91.8
Visits from ICDP and other officials	98.2	98.2	95.9	94.4

Table-32: Record keeping

	All		
	Available	Record date	Up to date
	%	%	%
Para Center Children attendance register	99.7	96.2	97.4
Reviewed by Supervisor on last visit	94.1	NA	88.8

+Para Center Stock register	97.6	NA	87.4

Pre-school Activities:

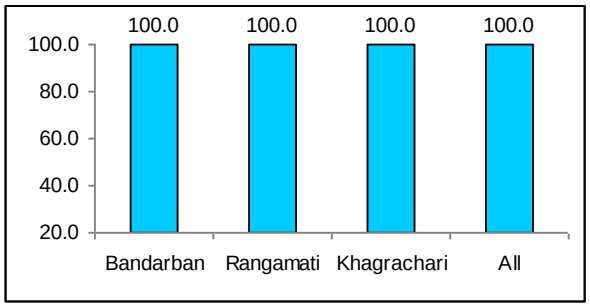
Pre-schools remain open 6 days a week, and on average remain open for 2:30 hours each day, making total of about 15 hours a week. All Para workers have reported to have received educational materials, and 99% received play materials. In 77 – 90% centers play materials were available, but in majority cases these were in good condition. In 99% centers story/picture book was available, and majority of them were found in good condition. Slate and chalk were available in 98% centers, and average quantity per center was 18 and in 55% centers these were found in tact (unbroken). Learning posters were showed and displayed in almost all the centers. Average number of posters found was 8 in each center, and majority of them were in good condition. Average quantity of mats for children to sit was 4 per center, but condition of majority these mats was not good. Blackboard was available almost everywhere, about 70% were in good condition. However, of the rest some need repair and some need replacement.

Table-33: Duration of schooling by days – Average

	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
Sunday	2.43	2.28	2.32	2.34
Monday	2.43	2.28	2.32	2.34
Tuesday	2.43	2.28	2.32	2.34
Wednesday	2.43	2.28	2.32	2.34
Thursday	2.43	2.28	2.32	2.34
Saturday	2.43	2.28	2.32	2.34
Total	15.42	14.60	14.78	14.88

Base - All Respondents

Graph-69: Incidence of educational materials received



Graph-70: Incidence play materials received

Figure in %

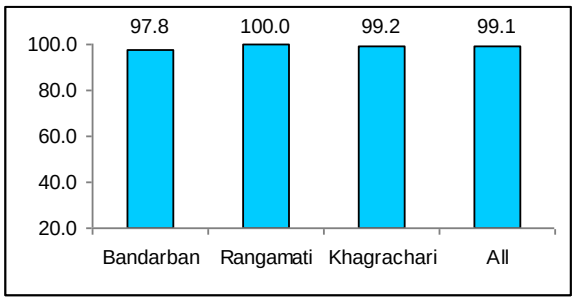


Table-34: Availability of play material and their condition

	Bandarban		Rangamati		Khagrachari		All	
	Available	Good condition	Available	Good condition	Available	Good condition	Available	Good condition
	%	%	%	%	%	%	%	%
Doll	77.5	44.9	93.0	74.2	98.4	63.3	90.9	63.4
Skipping rope	75.3	80.6	86.8	88.4	86.9	79.2	83.8	83.2
Wooden block	75.3	76.1	84.5	78.0	92.6	82.3	85.0	79.2
Counters	85.4	86.8	93.8	84.2	90.2	88.2	90.3	86.3
Kitchen toys	70.8	60.3	76.7	81.8	82.0	77.0	77.1	74.8

Graph-71: Availability of story/picture book

Figure in %

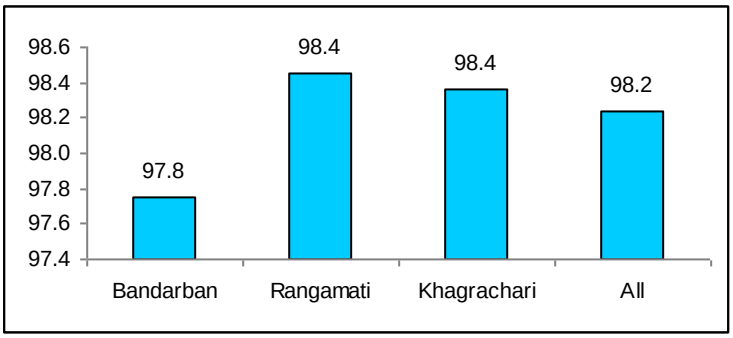
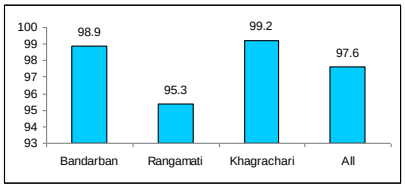


Table-35: Story/Picture book condition

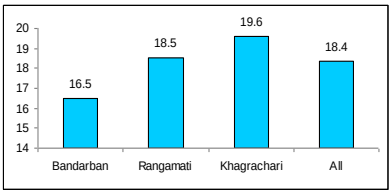
	Weather affected				Turn/page missing			
	Bandarban	Rangamati	Khagrachari	All	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%	%	%	%	%
None	77.01	73.23	70.00	73.05	81.61	81.89	75.00	79.34
Some	19.54	23.62	27.50	23.95	14.94	15.75	21.67	17.66
Most	2.30	1.57	1.67	1.80	3.45	0.79	2.50	2.10
All	1.15	1.57	0.83	1.20	0.00	1.57	0.83	0.90
Base- book available	87	127	120	334	87	127	120	334

Graph-72: Availability of Slate & chalk

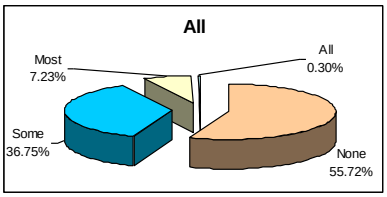


Graph-73: Number of slate & chalk available

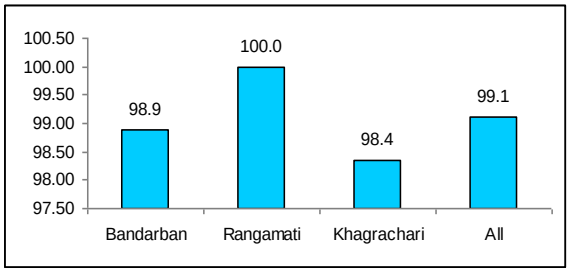
Figure in %



Graph-74: Broken slate & chalk found



Graph-75: Learning posters shown



Graph-76: Learning posters available

Figure in %

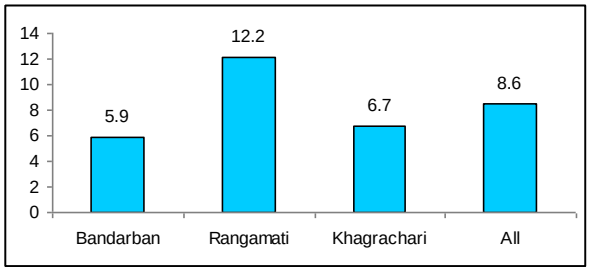
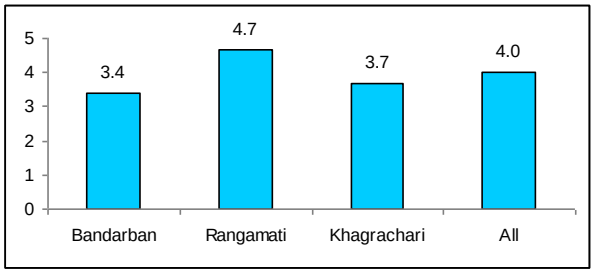


Table-36: Learning poster condition

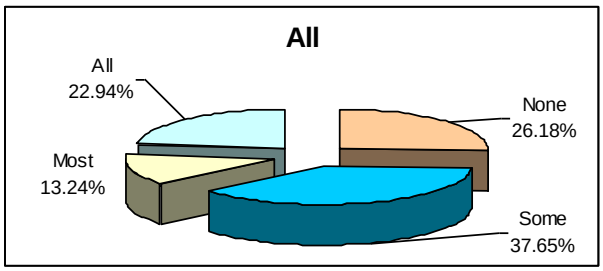
	Displayed				Weather affected				Torn/page missing			
	Bandarban	Rangamati	Khagrachari	All	Bandarban	Rangamati	Khagrachari	All	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%	%	%	%	%	%	%	%	%
None	1.12	0.00	1.64	0.88	85.39	73.64	57.38	70.88	80.90	90.70	60.66	77.35
1	5.62	9.30	9.84	8.53	4.49	9.30	24.59	13.53	8.99	5.43	19.67	11.47
2	13.48	5.43	8.20	8.53	2.25	10.85	13.11	9.41	2.25	2.33	13.93	6.47
3	15.73	1.55	9.84	8.24	1.12	3.10	3.28	2.65	1.12	0.78	4.92	2.35
4	64.04	83.72	70.49	73.82	6.74	3.10	1.64	3.53	6.74	0.78	0.82	2.35
Base	89	129	122	340	89	129	122	340	89	129	122	340

Graph-77: Mats for children to sit on (Number)

Figure in %

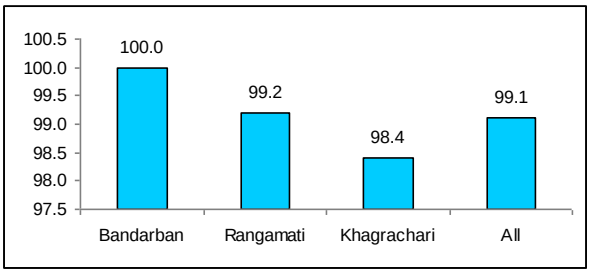


Graph-78: Mats for children to sit on (Condition)

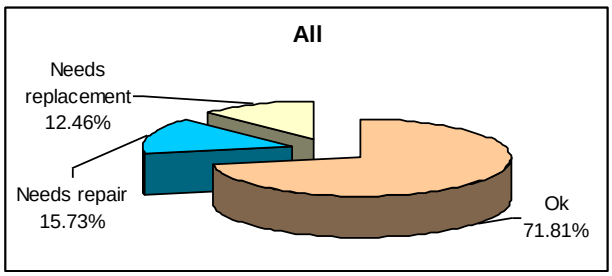


Graph-79 Blackboard Available

Figure in %



Graph-80: Blackboard Condition

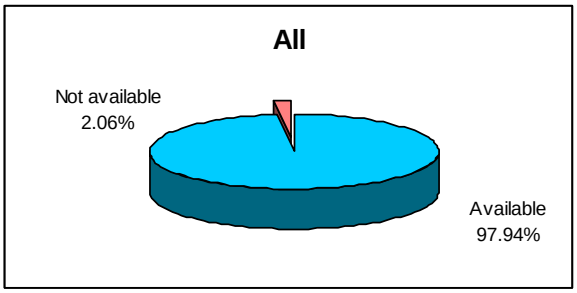


Profile of Preschool Children:

Date of birth and gender of children were available in most (more than 95%). In some centers these were missing. Average number of children was 14.1 per center out of 15.8 recorded on 31 October, which implies about 90% presence. However, in some centers there were more than 20 children. Most favorable activities of children included Games & sports, Singing/ listening same, Recitation of rhymes/ listening same and Story telling/ listening same.

The above findings show a better performance than that was found in the last evaluation survey, which indicated lower percentage of presence on data collection day.

Graph-81: Date of birth available



Graph-82: Gender of the child available

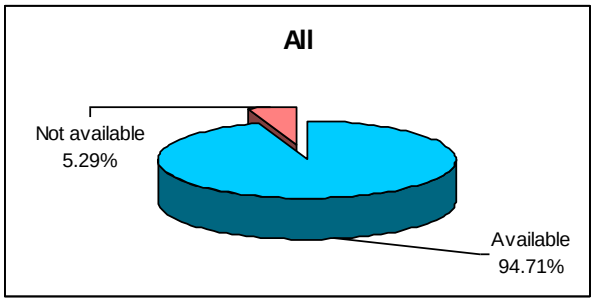


Table-37: Average number of boys & girls on 31st October, 2011

	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
3-5 years - Male	4.85	4.60	5.44	4.97
3-5 years - Female	4.97	4.89	5.43	5.10
5-6 years - Male	2.95	2.91	3.90	3.28
5-6 years - Female	3.08	3.01	3.82	3.33
Total - Male	7.38	7.09	8.87	7.81
Total - Female	7.52	7.50	8.85	7.99

Base - All Respondents

Graph-83: Number of children present on data collection day

Figure in %

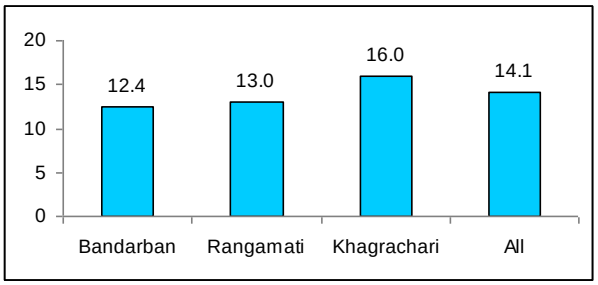


Table-38: Apparent most favorite activities of children

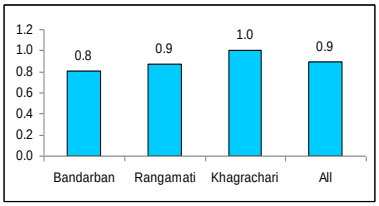
	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
Games/ sports	67.4	56.6	85.2	69.7
Singing/ listening same	43.8	46.5	54.9	48.8
Recitation of rhymes/ listening same	31.5	40.3	68.9	48.2
Story telling/ listening same	37.1	38.8	50.8	42.6
Dancing	5.6	14.7	13.1	11.8
Playing with dolls	7.9	18.6	3.3	10.3

Drawing pictures	4.5	14.0	8.2	9.4
Kitchen toys/utensils	9.0	14.0	1.6	8.2
Others	20.2	27.1	9.8	19.1
Base - All Respondents	89	129	122	340

Preschool to Primary School:

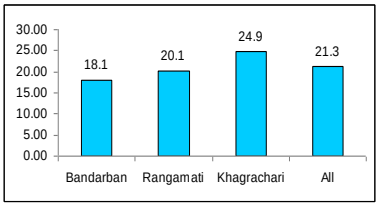
Most primary schools were found to be located within one km from the Para; only a few were beyond one km. On average it takes around 20 minutes to the school, almost everybody goes on foot.

Graph-84: Distance of nearest primary school from Center (km)

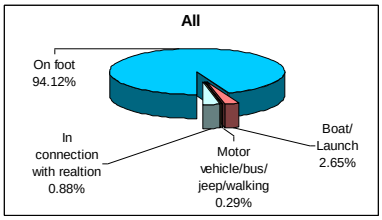


Graph-85: Time takes to primary school

Figure in %



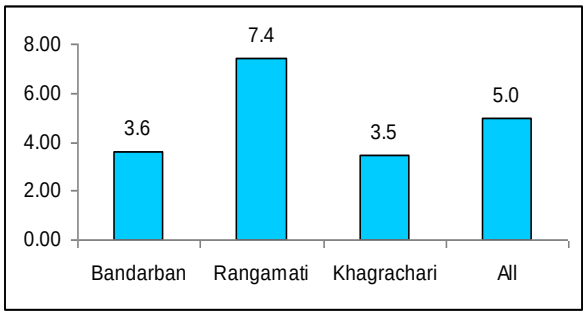
Graph-86: Mode of transportation



Health and Nutrition:

Access to Health Services: On average the nearest health facility was 5 km away, and it takes about 45 minutes to reach there. Type of facility mentioned was Health Center (50%) and Hospital (50%). Services available included treatment of General Diseases, Diarrhoea, Malaria, Antenatal Care, Family Planning, providing Vitamin- A capsule, T.T vaccine, Delivery, E P I, Adolescent Health Care, Tuberculosis, Pneumonia, etc. In case of pregnant woman experiencing complications would almost invariably be taken to the nearest Hospital. On average the nearest hospital would be 16 miles away. Majority would travel by bus. Many would have to take multiple mode of transport to reach the hospital. One would always find a doctor/trained personnel at the hospital who would provide necessary service to the patient.

Graph-87: Distance of nearest health facility (km)



Graph-88: Type of nearest facility

Figure in %

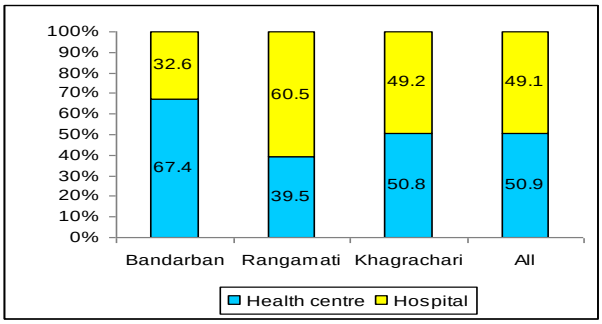
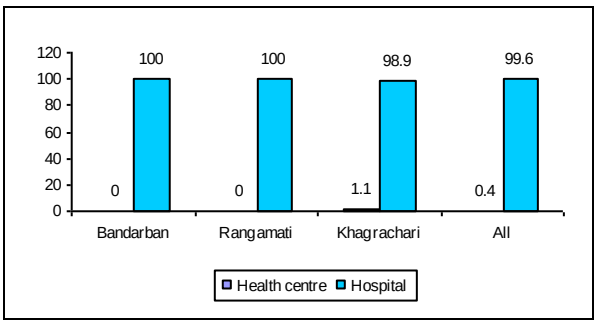


Table-39: Diseases treated in the nearest health facility

	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
General Diseases	98.9	94.6	95.9	96.2
Diarrhoea	73.0	82.9	90.2	82.9
Malaria	52.8	79.1	86.1	74.7
Antenatal Care	73.0	63.6	83.6	73.2
Family Planning	50.6	67.4	66.4	62.6
Vitamin- A capsule	48.3	46.5	85.2	60.9
T.T vaccine	39.3	50.4	81.1	58.5
Delivery	37.1	38.0	68.0	48.5
E P I	11.2	41.1	40.2	32.9
Adolescent Health Care	22.5	17.8	54.1	32.1
Tuberculosis	20.2	27.1	42.6	30.9
Pneumonia	4.5	5.4	52.5	22.1
Kala-a-Zar	4.5	1.6	41.0	16.5
STI/RTI/ HIV/AIDS	2.2	5.4	30.3	13.5
Leprosy	10.1	10.1	13.9	11.5
Primary Eye Care	3.4	6.2	23.0	11.5
Others	7.9	3.1	0.0	3.2
Base-All Respondent	89	129	122	340

Facility where a pregnant woman will be taken in case of experiencing some complication with the birth of her baby

Graph-89: Type of facility



Graph-90: Distance (km)

Figure in %

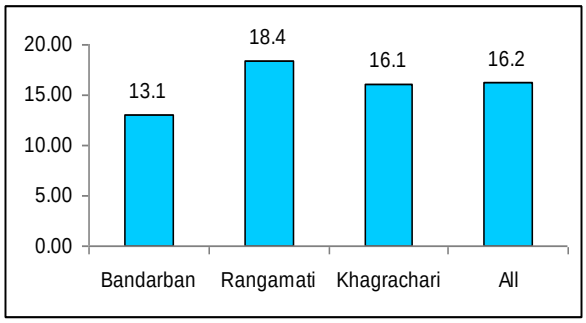


Table-40: Mode of Transport

	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
Bus/Jeep	75.81	47.78	61.70	60.16
Motor vehicle/ bus/ jeep/ walking	4.84	5.56	15.96	9.35
Boat/Launch	4.84	21.11	0.00	8.94
On foot	4.84	5.56	7.45	6.10
Motor vehicle/ bus/ jeep, boat and walking	0.00	8.89	3.19	4.47
Boat/ launch and walking	8.06	0.00	6.38	4.47
Motor vehicle/ bus/ jeep and boat/launch	0.00	8.89	0.00	3.25
Rickshaw and walking	0.00	0.00	4.26	1.63
By Rickshaw/Bi-cycle	1.61	1.11	0.00	0.81
Motor vehicle and Rickshaw	0.00	1.11	1.06	0.81

Table-41: Availability doctor/clinician at health facility who can provide Emergency Obstetric Care

	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
Yes	100.0	100.0	100.0	100.0
Base-All Respondent	89	129	122	340

Nutrition and immunization: Almost all women who gave birth were given vitamin A within 6 weeks of delivery. However, although the rate is high, not all children appear to have been given vitamin A or fully immunized as can be seen from the following tables.

Table-42: Average number of women who gave birth and received vitamin A

	Banderban	Rangamati	Khagrachari	All
Women who gave birth within 1 Oct 2010	4.04	3.92	3.93	3.96
Received Vitamin-A within 0-6 wks of delivery	3.92	3.71	3.88	3.83

Base - All Respondents

Table-43: Children received Vitamin A (Average number)

		Banderban	Rangamati	Khagrachari	All
12-24 months	Boy	3.08	3.50	4.90	4.12
	Girl	2.87	4.11	4.97	4.26
24 months-5 years	Boy	3.57	3.70	6.39	5.06
	Girl	3.98	4.04	5.93	5.00
5-6 years	Boy	1.77	0.82	1.70	1.50
	Girl	1.96	0.98	1.68	1.58
Do not know (%)		43.82	56.59	4.10	33.53

Base - All Respondents

Table-44: Immunization status of children

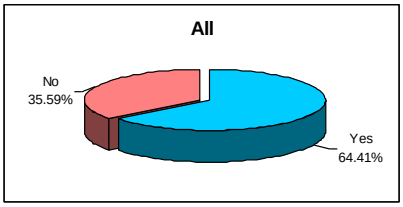
		Banderban		Rangamati		Khagrachari		All	
		Number	Number of fully immunized	Number	Number of fully immunized	Number	Number of fully immunized	Number	Number of fully immunized
1 year	Boy	2.69	2.13	2.57	1.61	3.27	2.65	2.88	2.15
1 year	Girl	2.41	1.80	2.36	1.54	3.51	2.55	2.83	2.01
2 years	Boy	1.41	1.17	1.15	0.68	0.89	0.86	1.1	0.86
2 years	Girl	1.68	1.42	0.87	0.70	0.9	0.9	1.07	0.94

Water & Sanitation:

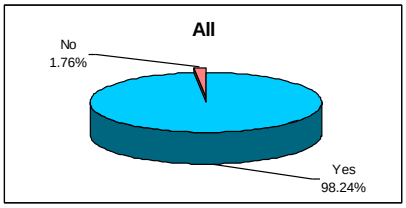
About two-thirds of Para workers reported to have received training on preparing community action plan for Water & Sanitation, and the rest opined otherwise. Almost all Para workers mentioned that their functions include providing information to the community members to promote hygiene. This is done mainly through courtyard meetings, and also through door to door visits and meetings at Para Center.

The last evaluation report also depicted similar picture that about one-third did not receive training on preparing community action plan for Water & Sanitation.

Graph-91: Incidence of receiving training

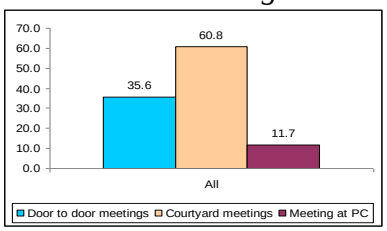


Graph-92: If work include proving promotional formation to the community members about hygiene



Graph-93: Method of providing hygiene formation to community members

Figure in %



Courtyard meeting: Courtyard meetings are held fortnightly. Information covers many areas, mainly health & nutrition and education related. Nearly one-fifth of the Para workers experienced preventing courtyard meetings, which were mainly due to Jhum cultivation, bad weather and sickness of Para workers. On average 3 meetings specifically on nutrition were prevented by such conditions.

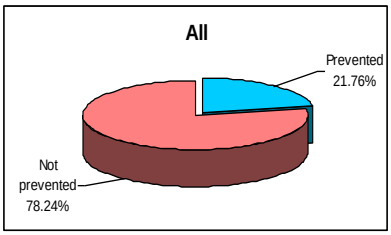
Table-45: Meeting frequency

	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
15 days	100.0	100.0	100.0	100.0
Base-All Respondent	89	129	122	340

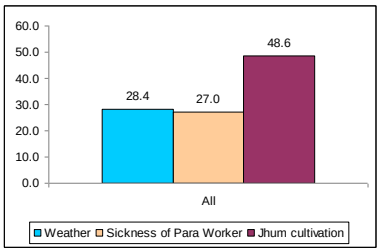
Table-46: Information coverage

	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
Healthcare/ health related information	31.5	44.2	36.1	37.9
Education	3.4	11.6	9.0	8.5
Nutrition	6.7	5.4	6.6	6.2
Diarrhea	11.2	0.8	3.3	4.4
Use of hygienic latrine/ Sanitation	4.5	3.1	4.9	4.1
Iodized salt	7.9	2.3	3.3	4.1
Pre-school	1.1	0.8	9.8	4.1
Safe water/ pure water	2.2	4.7	1.6	2.9
Breast feeding of babies	4.5	0.8	3.3	2.6
Vaccination of pregnant mothers	3.4	3.1	1.6	2.6
Children's vaccination	2.2	3.9	1.6	2.6
Vitamin 'A'	3.4	3.1	1.6	2.6
Right time of taking baby	2.2	0.8	4.9	2.6
Increasing awareness of pregnant women	2.2	3.1	1.6	2.4
Neat and cleanliness	5.6	0.8	0.8	2.1
Others	7.9	11.6	10.7	10.3
Base-All Respondent	89	129	122	340

Graph-94: Incidence of ever preventing courtyard meetings from being held

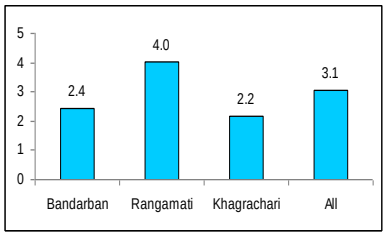


Graph-95: If 'Yes', what was the barrier?



Graph-96: Number of incidence specifically on Nutrition

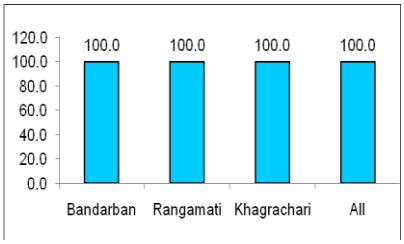
Figure in %



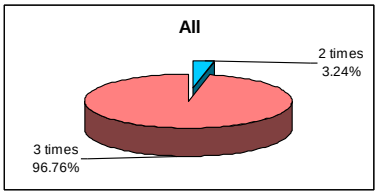
PCMC: Every Para Center has a management committee, and in the last 6 months almost all of them had 3 meetings on average, which are stated to be useful. Para workers suggested holding these meeting more frequently.

Graph-97: Existence of PCMC

Figures in %



Graph-98: PCMC meetings held in last 6 months



Graph-99: Usefulness of PCMC meetings

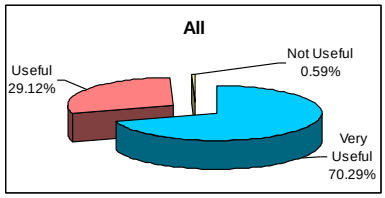
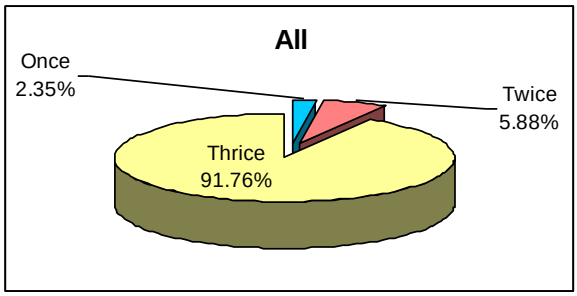


Table-47: Suggestions for making PCMC to function better

	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
No suggestion	60.67	34.88	58.20	50.00
Hold meeting once a month or more	13.48	35.66	25.41	26.18
Ensure regular presence of PCMC members	3.37	13.18	5.74	7.94
Training for PCMC members	12.36	10.08	1.64	7.65
Allowance for PCMC members	8.99	3.10	7.38	6.18
Presence of P.O. in PCMC meetings	2.25	4.65	1.64	2.94
Base-All Respondent	89	129	122	340

Cluster meeting: Most Para workers also mentioned that 3 cluster meetings held in the last six months, and most of which were also attended by their supervisors. Main topic discussed was about pre-school related matters. They also discuss about courtyard meetings, monthly report and health related issues. They suggested holding cluster meetings more frequently.

Graph-100: Cluster meetings held in last six months



Graph-101: Meetings attended by Supervisor

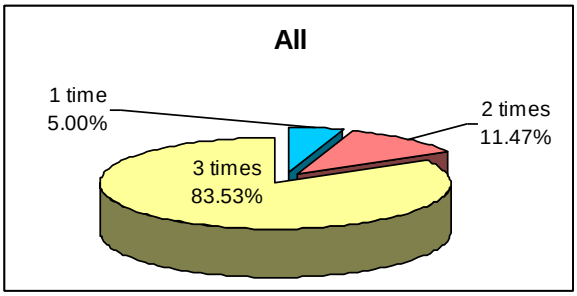


Table-48: Topics/issues discussed in the cluster meeting

	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
Conduct pre-school lessons/ conduct lessons/ regularly give lessons to children	36.0	47.3	59.8	48.8
Courtyard meeting	13.5	9.3	9.0	10.3
Monthly report	20.2	4.7	4.1	8.5
Health	9.0	10.9	4.9	8.2
Update all information/ to record all information correctly	13.5	5.4	4.9	7.4
Others	7.9	22.5	17.2	16.8
Base-All Respondent	89	129	122	340

Table-49: Recommendations/suggestions to make cluster meetings more useful and beneficial

	Bandarban	Rangamati	Khagrachari	All
	%	%	%	%
No suggestion	51.69	41.86	38.52	43.24
Hold cluster meeting once in a month	26.97	29.46	22.13	26.18
Discuss more about health carte in cluster meeting	7.87	10.08	9.84	9.41
Discuss more about family planning in cluster meeting	2.25	0.78	0.00	0.88
Increase honorarium for Para Worker for holding cluster meet	4.49	10.85	4.92	7.06
Discuss more about neat and cleanliness in cluster meeting	0.00	0.78	4.92	2.06
DPCs need to be present in cluster meeting	4.49	2.33	4.92	3.82
Better if cluster meeting can be arranged at a fixed place	4.49	5.43	22.13	11.18
Base-All Respondent	89	129	122	340

Supervision of Para Worker:

In the last 6 months about 40% Para workers raised Para center related issues with their respective supervisors. Of the issues raised, about one-third said to have been dealt properly. The rest could not be addressed apparently due to lack of fund/budget, inadequate supply of materials in the stock, etc. In the last visit most supervisors reported to have stayed in the center for up to an hour, and 80% of them met with PCMC, 43% with headman, little more than half (53%) attended courtyard meeting and 88% attended ECD class. About 82% Para workers stated to have learnt something from the supervisor in the last visit, which included teaching instruction, cleanliness, updating information, courtyard meeting, etc, which were found useful by the Para workers. More frequent visit by supervisors was suggested.

Graph-102: Incidence of raising issues with your Supervisor in last six months (1 May to 31 October)

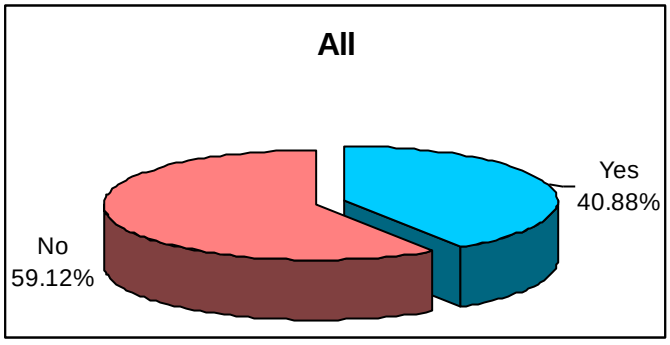


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Table-50: Issues raised

	Banderban	Rangamati	Khagrachari	Total
	%	%	%	%
Repairing of Para center	11.43	12.70	34.15	18.71
Repair of Bamboo fence of Para center	17.14	25.40	9.76	18.71
Repair of roof of Para Center	11.43	17.46	12.20	14.39
Providing toys for children	8.57	15.87	17.07	14.39
Para center doesn't have any latrine	17.14	11.11	4.88	10.79
Supply black board for pre-school classes	5.71	1.59	21.95	8.63
Supplying mats for sitting in Para center	5.71	1.59	21.95	8.63
Supplying Chalk for children	2.86	1.59	17.07	6.47
Repair floor of Para center	5.71	6.35	7.32	6.47
Latrine at para center was damaged by cyclone/ necessary to reconstruct the Para center's latrine	5.71	6.35	4.88	5.76
Others	40.00	15.87	19.51	23.02
Base - Those raised issues	35	63	41	139

Graph-103: If issues raised were dealt with in a satisfactory manner

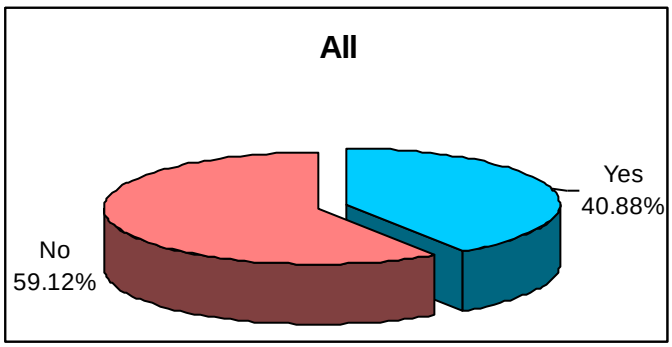


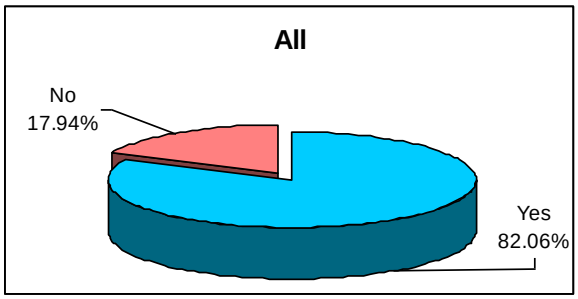
Table-51: Reasons for not dealing with satisfactorily

	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
Said it will be given, but haven't given as yet	41.67	39.02	37.50	39.33
No budget at the moment/ when new budget comes, repairing will be done/ when new budget comes reconstruction will be done	12.50	41.46	37.50	32.58
Not in the office at the moment/ when new lot comes , these will be given	45.83	19.51	29.17	29.21
Base - Those did not raise any issue	24	41	24	89

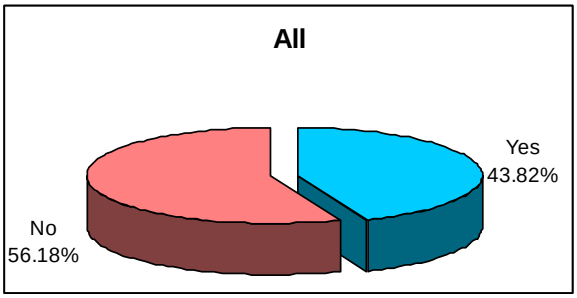
Table-52: Duration of stay in most recent visit by the Supervisor in the Para

	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
Less than one hour	41.6	14.0	24.6	25.0
1-2 hour	50.6	59.7	49.2	53.5
2- 3 hours	5.6	12.4	18.0	12.6
3-4 hours	1.1	9.3	6.6	6.2
4+ hours	1.1	4.7	1.6	2.6
Base-All Respondent	89	129	122	340

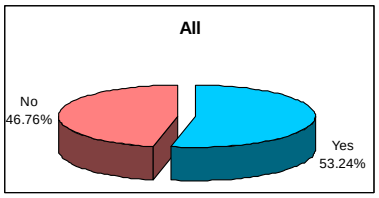
Graph-104: Incidence of meeting with the PCMC



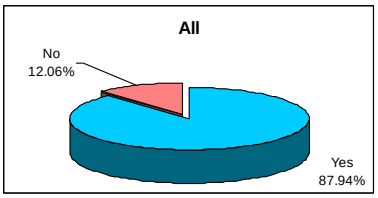
Graph-105: Incidence of meeting Headman



Graph-106: Incidence of attending courtyard meeting



Graph-107: Incidence of attending ECD class



Graph-108: If Para worker learnt something from Supervisor

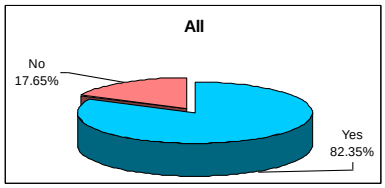


Table-53: Things learnt from supervisor's last visit

	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
About properly teaching the children/ to give lessons to children with care	36.5	50.0	41.4	43.9
About keeping Para center neat and clean	15.9	11.0	18.2	14.6
To update information	20.6	14.4	6.1	12.9
About holding courtyard meeting regularly	1.6	13.6	13.1	10.7
Others	25.4	11.9	21.2	18.2
Base-Those learned	63	118	99	280

Graph-109: Usefulness of learning from supervisor's visit

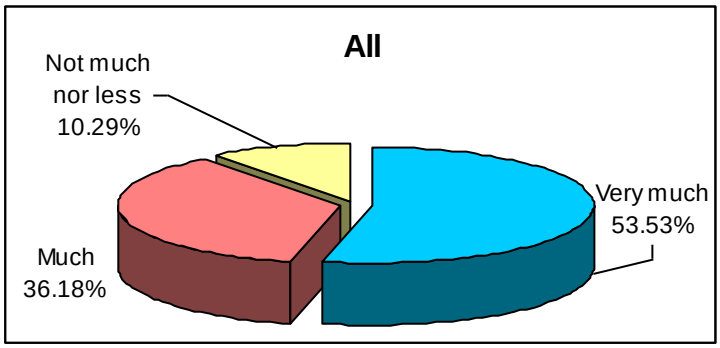


Table-54: Suggestions for improvement

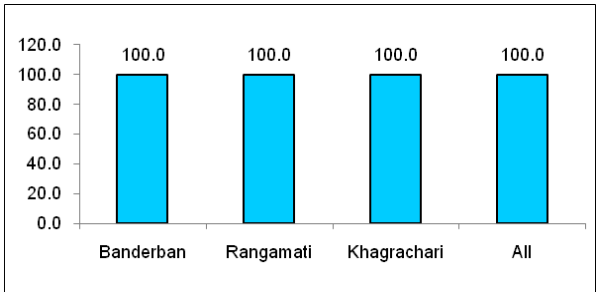
	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
Making more visit/ coming more to Para Center	22.47	42.64	50.00	40.00
Don't know/ can't say	52.81	30.23	37.70	38.82
Remain present on courtyard meeting	3.37	9.30	1.64	5.00
Regularly visit Para center	8.99	4.65	1.64	4.71
Visit Para center twice each month	3.37	6.98	2.46	4.41
Stay for more time during visit to Para center	8.99	1.55	0.82	3.24
To remain present in PCMC meeting	3.37	3.10	2.46	2.94
By increasing number of supervisors	0.00	2.33	2.46	1.76
Visit Para Center once every week	1.12	0.78	2.46	1.47
Base-All Respondent	89	129	122	340

Workload of Para Worker:

On an average week a Para worker works for 6 days, on average spends 18 hours a week and visits 6 households. About one-fourth of the workers perform additional activities other than ones performed as Para worker. Major such activities included Teaching children at home, Working along with health workers, Accompanying sick persons in the community to health facility and Taking part in national vaccination program.

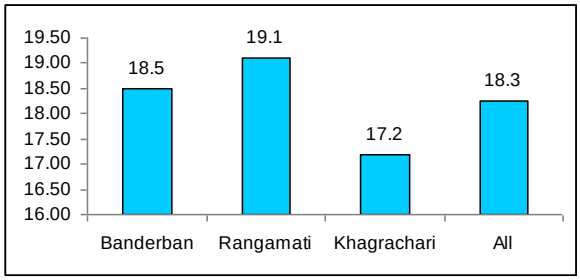
Similar findings were revealed in the last evaluation survey.

Graph-110: Percentage working 6 days per week as Para Worker



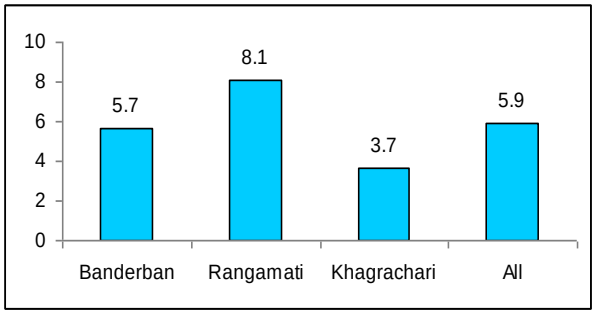
Graph-111: Average weekly working hours as Para Worker

Figure in %



Graph-112: Number of households visited in an average week

Figure in %



Graph-113: Incidence of providing additional services that are not specifically required as Para Worker

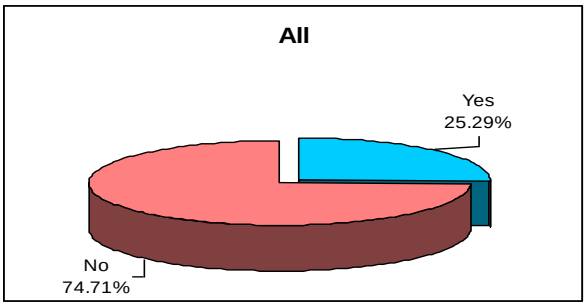


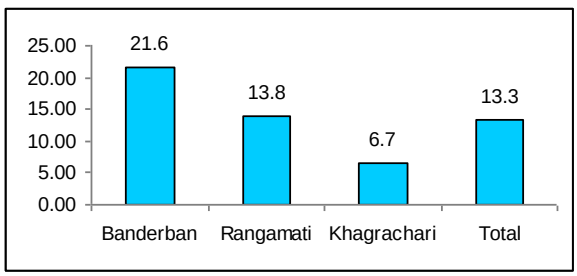
Table-55: Additional activities performed

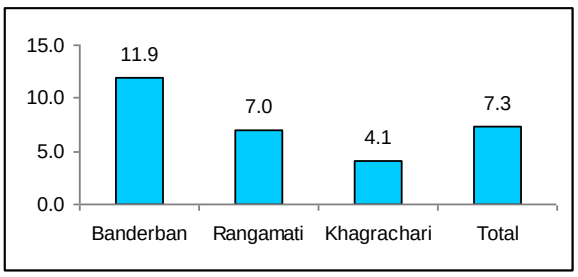
	Banderban	Rangamati	Khagrachari	All
Teach children at home	85.7	26.2	26.7	36.0
Work along with health workers	14.3	31.0	30.0	27.9
Take sick person to health facility	0.0	26.2	16.7	18.6
Take part in national vaccination program	0.0	21.4	10.0	14.0
Teach stitching to para women	14.3	2.4	13.3	8.1
Drop home pre-school children	0.0	2.4	16.7	7.0
Base - Those provide additional activities	14	42	30	86

Graph-114: Average number of days Para centers remained closed except on prefixed holidays in the last 12 months

Graph-115: Average number of times Para centers remained closed except on prefixed holidays in last 12 months

Figure in %





Opinions and suggestions of Para worker on the Project:

Nearly all Para workers felt the Para Center has benefited the community, and the benefits derived most were child education and awareness about health and nutrition. Para workers were not really able put forward any concrete suggestion regarding improvement of the center/project and areas of expanding its activities.

Table-56: Para services that are most beneficial for the community

	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
Education of Children/ Pre-school class	56.2	44.2	47.5	48.5
Courtyard meeting	10.1	13.2	17.2	13.8
Awareness on health	11.2	8.5	5.7	8.2
About hygienic latrine/ sanitation	4.5	6.2	3.3	4.7
Others	18.0	27.9	26.2	24.7
Base-All Respondent	89	129	122	340

Table-57: Ways Para Center project can be improved

	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
Through improved healthcare services from Para Center	4.5	10.1	10.7	8.8
By arranging pure water for Para community/ by sinking tube well	10.1	7.8	7.4	8.2
To motivate the pre-school children for lessons	3.4	8.5	2.5	5.0
To motivate the Para worker in her works by increasing her salary	7.9	3.1	4.9	5.0
By making the Para center pucca	2.2	3.1	9.0	5.0
By arranging for English education for pre-school children	3.4	2.3	8.2	4.7
By arranging for improved training for Para Worker	4.5	5.4	3.3	4.4
By repairing roads inside the paras	0.0	4.7	5.7	3.8
By upgrading pre-schools in to primary school	7.9	1.6	0.8	2.9
By setting hygienic latrine to Para community through Para center	2.2	6.2	0.0	2.9
Others	3.4	7.0	3.3	4.7
Don't know/ can't say	50.6	40.3	44.3	44.4
Base-All Respondent	89	129	122	340

Graph-116: If community has benefited from the Para Center project

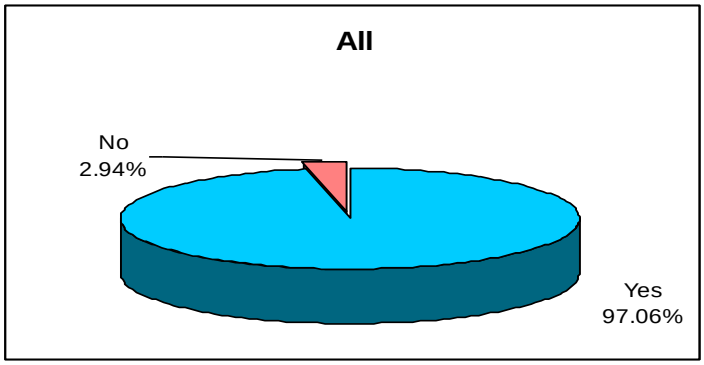


Table-58: Benefits derived by the community Para Center

	Banderban	Rangamati	Khagrachari	All
	%	%	%	%
Children able to learn/ educated/ they have developed in their education	65.5	63.7	68.9	66.1
Able to form correct idea about health/ becoming aware about health/ able to know about unknown matters on health/ able to learn about health related matters	15.5	10.5	9.8	11.5
Known about use of hygienic latrine	0.0	8.1	3.3	4.2
Able to know vaccine related information	2.4	1.6	4.1	2.7
Able to know about importance of use of iodized salt/ been inspired to use iodized salt	1.2	0.8	4.9	2.4
Others	15.5	15.3	9.8	13.3
Base-Those have benefited from the Para Center	84	124	122	330

6. FOCUS GROUP DISCUSSION:

In addition to quantitative findings as above, qualitative study was also carried out to find out the impact of integrated community development project on the people of the three Chittagong Hill Districts. The qualitative finding corroborates the quantitative findings in most of the areas covered by the project. As part of qualitative study Focus Group Discussions were carried out in all the three hill districts. Total 9 Focus Group Discussions were held (3 in each district). In Rangamati 2 male and one female group; in Bandarban 2 female and one male group and in Khagrachari 2 female and one male group were held. The number of participants in each group was 6 to 8 and all of them were program beneficiaries and were between the age of 16 and 55 years. The discussions covered various topics as follows:

- Water Issues
- Good water management systems
- Health Issues
- Immunization program
- Sanitation issues
- Family planning
- Education
- Hygiene issues
- Socio-economic rehabilitation
- Awareness
- Behavior changes among people of intervention and non-intervention areas
- Project Activities

Each of the group discussions took around 1.30 hours and representative of OrQuest moderated the group discussion with the help of a local aide who worked as interpreter between the moderator and tribal/ hilly people.

Detailed Findings:

6.1. Water issues:

A) Sources of drinking water

The discussion started by asking the participants about their sources of drinking water and how they usually collect same. Most of the participants confirmed that they usually collect water from tube well, well and Pipeline water. During the discussion the participants were asked how they collect water from their sources. Most of the participants informed usually they use pitcher (aluminum, zinc, steel, earthen) and bucket. The participants informed they use lid over the container to preserve water.

During the discussion the participants were asked about sources of collecting drinking water during last two years and whether they thought that water as safe or unsafe and condition of recent sources wherefrom they collect drinking water. Most of the participants answered that before two years they collected water from tube well, well water, ground water. But one female participant said that 5-6 years before she used to collect water from well. On safety issues of such collected water, one of the female participants said,

> *"Before 5-6 years there was no tube-well in my area. So, we had no other opportunity to drink water without well."*

(Khagrachari/Gr-1/ Female/35/ Class-IX/ Housewife)

Another participant said,

"During that time I didn't know what safe water is."

(Khagrachar/Gr-1/ Female/34/Illiterate/ Housewife)

Another participant said,

"I collected water from well before, after establishment of para center my source is now para center's tube well" –
(Khagrachari/ Gr-2/ Female/21/HSC/Housewife)

Another participant said,

"After establishment of tube well arsenic test has been done by local NGO and they said water can be used for drinking"
(Bandarban/Gr-5/ Male/35/Class- IX/ Agriculture)

During the discussion the participants were asked on their awareness of the safe water. They replied that before the ICDP intervention, the majority CHT people had low awareness about safe water. But now they are highly aware on safety issues. When the participants were asked, what are the things that make water safe; it revealed from the discussions that they have clear ideas about it. They responded that clear and pure water which are free from diseases, dust, microscopic organism, arsenic and iron can be considered safe. Water of tube well, fountain water, rain and boiled water can be considered as pure and safe water. Water from pond, canal, ground water and well water are considered as contaminated water and unsafe for drinking. Participants confirmed they are made aware on safe water through Para Workers, courtyard meeting, school meeting, advocacy meeting of UNICEF at para centers, NGO meeting, books and media.

Participants were asked about the difficulties in collecting water from its sources and the solution for same. Most of the participants answered that they do not face any kind of difficulties to collect drinking water. Government, UNICEF, Union Parishad, World Vision and with self contribution of para people tube wells were sunk in the paras. Almost all of the participants informed that the distance from household to the tube well is about 2-15 minutes' walk. Areas where numbers of tube well is low, respondent suggested installation of more tube well.

One participant said,

"In my para there are 44 tube wells, two families share one tube well at a time"
(Khagrachari/ Gr-1/ Female/25/Class-IX/Housewife)

Another participant said,

"We do face some problem because there is one tube well for lots of people. Need to wait too long to collect water"
(Rangamati/ Gr-7/ Female/45/Class- III/ Housewife)

6.2. Good Water Management System:

During the group discussion the participants were asked whether a good water management system exists. Most of the participants used tube well without any filter because they believe

tube well water is safe and pure to drink. Some participants informed they purify water by using tablet, boil and filter the tube well water. Participants, who use well water to drink, clean well once every week for safety and to keep it clean.

It revealed from the discussions that Para Workers, NGO workers inform about good water management to the participants in para meeting. They themselves are also keen in maintaining good water management system.

One participant said,

"We clean the well once in a week".

(Rangamati/ Gr-8/ Male/43/Masson)

Another participant said,

"After collecting water from pipeline, I use lid to preserve pure water."

(Bandarban/ Gr-6/ Female/ 30/illiterate/ Agriculture)

Another participant said,

"By covering the container of water with cloth, we can keep the water safe."

(Khagrachari/ Gr-1/ Female/40/ Class- XII/ Housewife)

Another participant said,

> *"Children tell us that their teacher told them to keep water covered with lid"*
>
> (*Khagrachari/ Gr-3/ Male/ 23/ Class- VIII/Service)*

6.3. Health Issues:

A) Hand Wash:

In this section discussion started by asking the participants about place where do they deposit/ dump household garbage and animals feces. Most of the participants answered they dig a ditch at the backyard of the house and dump there. Some of them said that they burn out the garbage and also throw them in the river bank or at any other dry place, away from house.
One of the participants said,

> *"We dump garbage in a set place."*
> *(Khagrachari/ Gr-1/ Female/ 28/ Class VI/ Housewife)*

Another participant said,

> *"We do throw dust a little distance from home, so that, household remain free from mosquito and flies". (Bandarban/ Gr-5/ male/ 18/ HSC/ Student)*

Discussions were held about awareness on washing of hand after defecation and before taking food/ feeding baby by the participants. Their responses were similar to each other. It revealed that they usually wash their hand after defecation, before and after taking food, before cooking, after sweeping their household and before feeding their children. Most of the time they use soap, ash, hot water, dry soil and hand washer. From the discussions they were found to be highly conscious about hand wash.

One of the participants said,

> *"For any purpose, if I go outside the home, obviously I do wash my hands before entering inside" (Bandarban/ Gr-4/Male/ 40/ Housewife)*

Another said,

> *"Before breast- feeding I do my hand wash."*
> *(Khagrachari/ Gr-2/ Female/ 27/ Class-IV/ Housewife)*

Another said,

> *"Everybody uses soap in their bathroom"*
> *(Bandarban/ Gr-4/Female/16/ SSC/ Student)*

Most of the participants receive information on importance of hand wash from media i.e. television, radio etc. They also receive information on this from Para Workers, health complex, from the hand washing programs held in schools; NGO meeting (World vision), Courtyard meeting, and some of the participants informed that most of the time children bring home this information from their school.

One of the participants said,

> *"One day I noticed a soap case in the toilet. My child brought it after being advised by his teacher to wash hands properly"*
> *(Khagrachari/ Gr-3/ Male/52/SSC/ Business)*

Another said,

> *"I am informed about hand wash by Para Worker."*
> *(Khagrachari/ Gr-2/ Female/ 30/ Class VII/ Housewife)*

Another said,

> *"After teaching the proper way of hand wash to children, a competition was organized among them." (Rangamati / Gr-7/ Female/36/SSC/ Housewife).*

B) Immunization:

During the group discussions, the participants were asked whether immunization program is presently running in their area and usually where they go to vaccinate and how do they know about immunization program. All the participants said that they are introduced about immunization program and it's an active program among their area. Usually they learn about the immunization programs from the Para Worker, miking, doctors, BRAC worker, Immunization Card (dates are written at the back), board at health center, and EPI workers. To attend immunization program they visit hospital, Health Complex, Para center, Community clinic and someone's house where vaccination take place. Vaccinations often take place in the PCs and the Para Worker makes sure that all the children in the community attend the vaccination program and are vaccinated. So it is clear that the inhabitants of the para centers are highly conscious about the immunization program. It is one of the duties of Para Workers to increase the awareness in the community and especially among pregnant women about the necessity of immunization programs. It is not included in the duties of Para Workers to perform any vaccination herself. Through discussion it is revealed that from Para centers vitamin 'A', Iron tablets are distributed among children, Pregnant women and girls on a regular basis.

Maternal and new born infants are linked with one another. A malnourished mother is at risk of giving birth to a low weight baby. During the group discussion the participants were asked about the vaccination of pregnant women, adolescent and children and the reasons for not vaccinating them. In response, the participants said that in their area there are no women, children who are non-vaccinated. Participants are aware about tetanus vaccine. Participants know female (15-49 years) should be TT vaccinated. So it is clear that the people of the intervention areas are highly conscious about Immunization and they highly appreciate this program.

One respondent said,

> "*If any children are vaccinated they would be free from hepatitis- B. Female between 14 and 49 years should be vaccinated 5 times with TT vaccine"*
> *(Rangamati/ Gr-9/ Male/38/ illiterate/Agriculture)*

Another participant said,

"To prevent children from Polio, Tuberculosis, whooping-cough they should be vaccinated on regular basis"

(Khagrachari/ Gr-1/ Female/ 35/ Class V/ Housewife)

During group discussion participants were asked about maternal mortality. In response, participants said they are informed about the complexity during delivery. Low awareness among women about nutrition, requirements of iodine and Vitamin -'A' and management of infectious diseases have contributed to a high occurrence of childbirth with low weight. Obstetric complications and a relatively high mortality is presumably a major problem in the remote areas. Participants were informed about pregnancy/ delivery complexity through Para Workers, Television, Health worker, Courtyard meeting and NGO meetings. Respondents reported the maternal death rate is almost zero now a days. Before 5-6 years some maternal death were found because of hepatitis, anemia, carelessness, non-vaccination and malnutrition. In response to question, where do they usually go when they have pregnancy related complications, they said that generally they go to Hospital, Mother Care Center, Thana health centers, Surjer Hasee clinic or to Para Worker. The courtyard meetings most often deal with issues concerning maternal health and care of mother. It was reported that previously immunization of pregnant women and of children was even more limited in the remote areas. Participants recommended if vaccination can be done at PC, then it would be easier for the community people.

One of participants said,

"At present we have PC and Para Worker. With the help of Para Worker we know everything about maternal mortality and now are aware about this. As a result mortality rate has decreased."

(Khagrachari/ Gr-1/ Female/38/Class IV/ Housewife)

Another participant said,

"Earlier we didn't know anything. Now Para Worker visits houses minimum once a week. If any kind of complexity is identified, she takes pregnant woman to Upazila health center or mother care center"

(Khagrachari/ Gr-1/ Female/40/ Class V/ Housewife)

There has been a low use and availability of health services in CHT. Most of the time doctors are not available as was reported by participants. So they take treatment from Nurse or the health service providers. Many paras are situated at a far distance from the nearest health service center. Respondents reported that if the Para Worker has knowledge about health facilities, this could be a great advantage and aid for community people. Anemia has been a severe public health problem in pregnant women. Most of the participants informed that para worker distribute iron tablets among adolescent and pregnant women. In the courtyard meeting para workers inform community people about anemia and advise them to take more vegetable and nutritious foods.

So, it is clear that through the help of Para Worker, community people gain knowledge about maternal care. Now they are aware and conscious about it. Para Worker is responsible for collecting information on the number of pregnant women in the para, the need for Vitamin-'A' for the post natal supplement to mothers and infants in their paras. The death rate is almost zero and all of the community people came under vaccination. Importance of vaccination is well-known to them. Through this knowledge, they have been able to develop themselves.

During the discussion respondent were asked about their knowledge on infectious diseases, ways to prevent and how are they were informed about it. Through discussion it revealed Malaria, Cough, Tuberculosis, cholera, typhoid, leprosy, eczema, and measles etc. are known as infectious disease. The participants said infectious diseases can happen due to lack of neat and cleanliness, if pure water is not taken and if mosquito nets are not used. Usually they are informed about infectious diseases through Para Worker, television, courtyard meeting, NGO workers, and health service provider. It revealed through discussion that to prevent infectious disease community people should be timely vaccinated, should remain neat and clean, use mosquito nets and use sanitary latrine. Most of the time the NGO gives them mosquito nets.

One of the participants said,

"If we don't use mosquito nets, infectious disease can spread over the area"
(Rangamati/ Gr-8/ Male/45/ Rickshaw van operator)

Another participant said,

"We are aware for our own benefit. If children's foods are not hygienic; they can be attacked with diarrhea, cholera. So we are so much conscious."
(Khagrachari/ Gr-3/ Male/ 38/ Class V/ Business)

From the group discussion it can be said community people are now alert about infectious diseases. They are aware about usage of mosquito nets and vaccination. Most of the time community people take help/ suggestions from Para Worker on healthcare issues, which is the sign of increasing awareness about health among the community people. Awareness increases, protection also increases and threat decreases.

C) Sanitation Issues:

During the discussion participants were asked about latrine facility in their house, installation of latrine, usual places for defecation and urination and reasons of inconvenience regarding latrine installation, if any. Most of the participants answered they have their own facilities. They use sanitary latrine which are basically made by ring and slab, fenced by tin / bamboo. But some participants from Bandarban reported that till now they use hanging latrines or open air defecation. Sanitation facilities were built by their own fund, NGO (World vision), BRAC, UNICEF, Para Worker (lent money). Some of participants reported UNICEF distributes ring for installation.

One of the participants said,

"Defecation in the open air is not healthy; rather it is unhealthy."
(Khagrachari/ Gr-2/ Female/ 21/ HSC/ Housewife).

Another participant said,

"People who don't have any sanitary latrine facilities; use hanging latrines or defecation in open air." (Bandarban/ Gr-4/ Male/ 22/ Class VII/ Housewife)

It was revealed that for installation they were inspired through different NGO meeting, UNICEF meeting, School meeting, Para Worker. Now they are well aware what is sanitary latrine and how to maintain it. Participants reported that to keep latrine neat and clean, almost all the time family heads are responsible. Besides these, others members of the family take part to do it. In the latrine, people usually carry water from outside and sometimes some of them stock water by using bucket or container. Usually they use soap, brush to maintain/ clean the latrine and keep it healthy. To investigate sanitary latrine's condition, sometimes Para Worker visit household randomly.

One participant said,

"Sometimes Para Worker visits our household once every month to inspect latrine condition." (Khagrachari/Gr-1/ Female/ 35/Class 35/ Housewife)

From recommendation of those families who don't have latrine facilities, it revealed in group discussion, that they need help from local organization (NGO, UNDP, UNICEF etc.) and local government.

Another participant said,

" If NGO helps them in installation of latrine , this problem can be solved." (Bandarban/Gr-4/female/19/SSC/ Student)

The percipients said that they received awareness on sanitary latrine maintenance from different sources. They mostly rely on Para Workers and NGO workers for any kind of information on health and hygienic issues. In Bandarban districts they use hanging latrine or defecate in the open because they do not have their own fund for installation. However, the situation has improved especially in Khagrachari and Rangamati. So a high demand for community awareness about health, water, environment, education and sanitation is necessary.

D) Family Planning:

With regard to family planning issues, groups were asked about their knowledge on family planning and its sources. It was revealed that participants were highly conscious about it. They believed if they maintain family planning it will be helpful for the education of their child and for their financial condition. They maintain different types of protection for family planning. Among them injection, Norplant and pill are popular. They were informed about this by the Para Workers, in courtyard meeting, health worker, TV, Adolescent meeting, and NGO meeting. Some of them reported that they got training from world vision. Now they know why they have to maintain family planning and why it is necessary. Some of the respondent reported if PC supplies them family planning materials it can be great help for them.

E) Hygiene Issues:

During the discussion female participants were asked about hygiene issues during menstruation. Respondents reported that most of the time adolescent girls gain knowledge from their mothers but because of sensitive issues girls usually share their concern issues with Para Worker and courtyard meeting. Meetings for awareness on hygiene are mostly organized by NGO. Females take part there separately. Meetings distribute some books of awareness to the girls. In the BRAC health center, every week one meeting on hygiene is held, through which girls gain knowledge. In addition, the Para Worker also helps them to learn of these issues.

One of the participants said,

"Para Worker distributes Iron tablets among adolescent. Asked them to take iron tablet until they are between 14 and 49 years. If they have anemia, this can be recovered."
(Khagrachari/Gr-1/ Female/ 28/ Class VIII/ Housewife)

It revealed from the discussions that not only male or female but also adolescents of the intervention area equally get knowledge from Para Worker. They are exceedingly conscious about the hygienic issues in time of menstruation. So awareness is increasing among adolescents.

F) Education:

Education facilities have been very limited in the CHT districts. A high proportion of children living in the most remote areas have been deprived of education. Previously the enrollment rate of children in primary school was low especially in the remote areas, but also generally among the indigenous population living in relatively accessible areas. A major cause of limited enrolment in school was language barrier. The indigenous population speaks their own language and all education in primary and secondary school is carried out in Bengali. During the group discussion the participants were asked about the reasons of low enrollment rate, enrollment of children in education program (Pre-school), circumstances of pre-school education facilities, access to education among children, dropout rate in primary school and educational benefits which are offered. Most of the respondents reported that few children had dropped out of the pre-school activities. Drop out cases occurred due to lack of parents' awareness of the important of education. Most children who had completed the pre-school had been enrolled in a primary school. Children who had dropped out from school help their family for household chores and '*jhumjhum'* cultivation. Most of the respondents said Para Worker herself admitted children to school when their age was 5-6 years.

Another respondent said,

> *"Para Worker herself admitted children to the school" (Rangamati/ Gr-9/ Male/ 47/ Agriculture)*

All the respondents reported that all para centers (Pre-school) had been equipped with education and play materials. The education materials were well preserved. Information about weekly teaching program was presented by posters on the walls in the centre that daily two hours session shifted between alphabet, numerals and natural history and singing, playing and doing physical exercise. The teaching was mainly performed in Bengali.

One of the respondents said,

"Children are very interested; even they want to go to school during the holiday"

(Bandarban/Gr-5/ Male/23/SSC/Student)

All the respondents agreed that their children are so much curious to attend pre-school. After completing pre-school activities, Para Worker herself admitted them to primary school. Most of the participants answered that their children who attended pre-school performed well in primary school compared to others.

Another respondent said,

"I have a niece. Before entering in to pre-school, she could not talk. But now she can sing."

(Rangamati/ Gr-7/ Female/ 33/SSC/Housewife)

Besides this through discussion it revealed that children received biscuits, breakfast, warm cloth, chocolates from schools which increase their interest and concentration. Again, they can learn, sing, dance, story telling and recognize alphabet both in English and Bengali. So it is a sign of prospect that community children can learn Bengali by pre-schooling. Once it was major barrier for indigenous people to be educated. It is revealed from the discussion that there are no social barriers for education among female. Female receive different types of facilities from government i.e. free books, pen-pencil, stipend etc. To motivate attending rate in the school all the respondents recommended that monthly fees of schools should be decreased, the stipend program should be extended both for boys and girls and dress distributions should be included.

It is clear from the discussion that the rate of non-enrollment and drop out has decreased now and children are eager to join pre-school. After completing it, parents cordially enrolled them to primary school which is the sign of changes and it revealed from discussion that those pupils who had completed pre-school exhibited a greater eagerness for learning, having some basic literacy and numeracy skills and manifesting more enquiring attitudes. Community people are now more conscious about the issues of education and ICDP component of pre-school education is satisfactorily implemented.

6.4. Poverty:

During the discussion the respondents were asked about the sources of regular saving habit in spite of all the hardships of poverty, name of socio-economic organizations where they are members for long time and micro-credit facilities. Most of the respondents reported that they save money from snack, poultry firm, vegetable cultivation, household consumption, stitching etc. Most of the respondents said they save money by DPS.

The discussion revealed that most of indigenous people have membership in ASA, Grameen Bank, Eipsha, BRAC, and others. There is no loan facility in UNICEF. Sometimes few NGO give them loan, seeds, pig (BNKS), ginger seed and Mohila Somiti and UNDP give them loan to buy domestic animal (Cow/ Goat).

Some of them received loan from different NGOs. During the discussion they answered that by using this loan improvement took place in socio-economic condition of their family.
So through the discussion it is clear that a micro-credit scheme is one of the major parts to improve socio-economic condition. Community people can realize the value of it which is the great sign of development and awareness.

6.5. Awareness:

During the discussion the respondents were asked about infectious disease, awareness of infection and their prevention. All of the respondents know about infectious disease and their reasons. Most of the respondents reported that almost all of the diseases occur due to lack of neat and cleanliness, not using safe water, malnutrition and bad hygienic environment. Most of the respondents reported that they were informed and got knowledge from Para Worker, Television, NGO workers, health service providers, doctors, courtyard meeting, school meeting and books.

Only prevention can save people from infectious disease and this was reported by respondents. To prevent night blindness people should take more vegetables, Vitamin –'A' and nutritious foods. Besides this, worm infestation is other infectious disease. To get prevention from worm infestation there is no other way without neat and cleanliness. Anemia is one of the diseases among the pregnant women and adolescent girls. To overcome anemia women should take nutritious foods. This information was revealed from the discussion. Some of the respondents reported that Para Worker distribute Vitamin- 'A' and Iron tablets among children and women.

To summarize it can se said that community people has increased their knowledge on the issues of health, hygiene and awareness. They have high level of awareness, which is the indicator of effectiveness of the ICDP project.

6.6. Gender Issues:

During the group discussion the respondents were asked about the gender disparities in relation to girls' access to education and women's involvement in decision making forum. It revealed that human rights principals are applied in the household. Most of the respondent answered that there are no barrier to female education. For decision making, women take important role in their families. Today's community people are too flexible about the issues of decision making. They do accept that their female family member has equal rights to contribute to decision making in the family.

So gender disparities at all level is decreasing and inclusion of women is taking place in decision making bodies. Through the discussion it can be easily understood that community people are highly flexible on the issues of gender which is the indicator of development.

6.7. Geographical Issues:

During the discussion the respondents were asked about the distance from household to para center and difficulties to attend meeting/ other activities held in para center. Participants who were present in the group discussion informed that distance between para center to their household is not too long. Para centres were constructed in the vicinity of, or in the centre of the paras. So that inhabitants of that para visit PC within a short period of time. Most of the participants reported that they need 2-15 min to reach in PC. They don't need any kind of transportation. They visit para center on foot. Most of participants reported that usually they don't face any difficulties to visit PC.

Yet one participant said,

"Because of excessive rainfall, roads become muddy and walking is difficult."

(Rangamati/ Gr-9/ Male/ 44/SSC/ Business)

The participants were asked about ownership of land of PC. In response, they said that Communities provided the land, the labor and basic materials for the construction of the centers. In some case Para Worker herself, Para Worker's relatives and committee members are the owner of land. They reported that in exchange of getting job as a Para Worker, their family / their relatives agreed to give land for para centers. Some of the respondents recommended that if there would be stairway in the para center it could be easy to walk up to that.
From discussion it revealed that Para center are established in a central place, where it is more comfortable for the community people to arrive. So, community people visit PC in case of any difficulty and attendance rate of children at pre-school is satisfactory.

6.8. Behavior Change:

Participants were asked about any notable difference in behavior practice between the members of intervention area and non-intervention area. Almost all participants answered that they have found some differences among intervention and non-intervention area. Participants said community people of intervention area are aware about health, safe-water, hygiene, infectious disease, immunization and education etc. Children of intervention area receive pre-schooling. Through pre-school they are able to learn alphabet, Bengali language, health issues, hygienic issues, sing, dance and story telling. From pre-school, children receive Vitamin-'A', warm cloth etc. which is completely impossible in non-intervention area. During the primary school comparatively children who come from intervention area perform better as compared to non-intervention areas.

One of the participants said,

"From very childhood our children receive education through para center. But children of non-intervention areas are deprived of it. Our children get Vitamin-'A' tablets, Iron tablets, chocolates and warm cloths. But inhabitants of non-intervention are deprived of those. "

(Rangamati/ Gr-7/ Female/ 22/Class IX/ Housewife)

The participants reported that awareness of issues and behavior are completely different between people of intervention and non-intervention areas. Courtyard meetings are arranged in intervention area, which help community people to learn and be aware. But in non-intervention area, community people are totally deprived.

Another participant said,

"The inhabitants of non-intervention area are unaware about education. But we get all types of facilities. "

(Bandarban/ Gr-4/ female/ 20/ Class VI/ Housewife)

It is revealed from the discussion that inhabitants of intervention areas are polite in their behavior as compared to people of non-intervention areas. All of the participants reported that para center plays important role for such type of changes.

From group discussion it is clear that Para center are relevant to its works. Inhabitants of the para centers are benefited through para centers. So, as a result there are significant changes in behavior among the inhabitants of intervention areas. But in non-intervention areas this is completely different.

6.9. Project Activities:

During the discussion participants were asked about project activities. This includes the quality of communication among Para worker and beneficiaries, Para Worker's knowledge, materials of understanding, vital role of Para Worker, maintenance of the centers and service delivery of para centers.
Regarding quality of communication among Para Worker and beneficiaries, most of the participants are satisfied. Some of them reported that Para Worker visits once per week, some said twice and some said once a month. But maximum said twice a month.
Para Worker visits frequently the inhabitant's home. Some participants said that Para Worker visits a home with pregnant women several times. Sometimes Para Worker visits their home because of birth registration. Inhabitants who have children 3-5 years bring them to pre-school for early education.

One of the participants said,

> *"Children who don't attend school, Para worker visits their home and persuades them"*
>
> *(Bandarban/ Gr-6/ Female/ 35/ Illiterate/ Day laborer).*

Para Worker is so friendly and well mannered. Her friendly behavior helps community people to share their problem with Para Worker. It is revealed from group discussion most of the participants believe Para Worker are knowledgeable and expert. Participants reported that the education level of Para Worker is between class 9 and Class 12. All of them agreed the Para Worker should be more educated and efficient. Almost all of them recommended that Para Worker should be trained. They mentioned that health is the one of the issues in which Para Worker should be train up more. From the discussion it is clear that inhabitants of the intervention areas are satisfied with the Para Worker.

Participants were asked about the topics of in the courtyard meeting by Para Worker. Participants said that courtyard meetings are held twice in a month. Most of them take place in the area of school and yard of local inhabitants. Participants of courtyard meetings are mostly women and girls. The main issues of courtyard meetings are heath , hygiene , safe water, education , idolized salt, early marriage , immunization , mother's care , neo-natal care , post natal care , malaria, breast feeding , hand washing , family planning , adolescent health care etc. Almost all participants agreed that courtyard meeting is helpful for them because they got basic knowledge about different issues which help them to be more aware. Through courtyard meeting participants can learn about test of idolized salt, can know about symptoms of AIDS, nutrition, pre-school education and learn how to make oral saline. Participants said most of the time Para Worker use flip chart, board, picture etc. in courtyard meeting. Sometimes Para Worker paints some picture to make the participants understand. Most of the participants

recommended that techniques of teaching should be developed by distributing books, using their own indigenous language and sometimes by distributing lesson through CD.

It revealed that courtyard meeting played important role among the inhabitants of intervention areas. They don't face any kind of difficulties to organize courtyard meeting. Courtyard meeting could be made more useful if it includes teaching on methods of cultivation and stitching which may help community people to increase household income.

In the discussion participants were positive about the vital role played by Para Worker. Most of the participants agreed that Para Worker plays an important role in their Para center. With the help of Para Worker participants receive benefits and increase their awareness. Some of them reported that for need of personal help (maternal care, they visited Para Worker and she gave them fruitful suggestions). Participants recommended for training of Para Worker to make her more skilled and this should be mainly on health issues.

One of the participants said,

"Health related training should be given to Para Worker*". (Bandarban/ Gr-5/ male/ 30/ Class V/ Business)*

Most of the participants reported that they go to Para Worker in case for any complexity. Through Para Worker they get solution to their problem. About maintenance of Para Center, they answered Para Worker renovate it by herself. Para centers were constructed in the vicinity of, or in the centre of the paras. Communities provided the land, the labor and basic materials for the construction of the centers, whilst UNICEF provided the roofing materials (corrugated iron sheet). Most of the time children of pre-school help her to repair. Participants believed they should also take part for fixing Para Center.

Participants were asked about the service delivery condition of Para Center. All of the respondents answered that the Para Center provides health facilities. Para Worker distributes iron tablets, Vitamin A tablets, worm infestation medicine, and pre-school education kits; in some paras the immunization program takes place in the Para Center.

It was revealed through discussion that inhabitants of paras are contented with performance of Para Center. Most of the participants said that they would not disassociate themselves from all the activities if the Para Center provides them all facilities. From pre-school children are able to learn Bengali language and recognize alphabets. Some of participants recommended that Para Center should be organized properly with installation of tube-well, sanitary latrine, facility of electricity and fan.

Some important recommendations were made in the group discussions. About the health facilities, participants said if there could be a health service provider in Para Center then it would be a great aid for them. Medicines can be distributed from PC (i.e. Vitamin, iron tablets, worm infestation medicine, saline etc.). Some of the participants recommended making equipment available for malaria test, regular check-up for pregnant women and immunization facilities in Para center so that the inhabitants of intervention area would not go away. Most of the participants who were female recommended that Para Worker should give brief males also about the care of maternal health (neo-natal care). As recommendation, most of the participants said center of pre-school should be repaired and built by bricks and playing equipment should be increased (i.e. Cradle).

About the knowledge of Para Worker, all of the participants said Para Worker should be trained in different sector of awareness to develop her skills. Some of them recommended that Para Worker's salary need to be increased and a bonus should be included.

The salient findings from the group discussions are as follows:

- The relevance of the project is evident. There was and still is a high demand for increased community awareness about early child development and education, about health and nutrition and about water, environment and sanitation.

- It revealed through the discussion that Para center now become a focal place of all social activities. Overall, the project is being managed with efficiency and it revealed from the discussions that the administration of the para centers is well managed.

- Community people are satisfied with the management and efficiency of the Para Workers and Centers as a whole.

- The community involvement has been increased which is the indicator of sustaining of this project.

- The evaluation reveals that the targeted women and children have access to services provided by para centers and this has increased a lot over the years. The intended beneficiaries of the project have actually benefitted.

- From the group discussion it was learnt that the Para Center and Para Workers are the integral part of the people and they are being benefitted, not just looking from outside but this is the feeling of the people themselves. They want to see the Para centers providing more and more services and they are now aware of their healthcare, children's education, sanitation and waste disposal and decent way of living.

- The lesson learnt is any integrated community development project with close follow up is bound to produce tangible results and people are benefitting without a doubt. Therefore, replicability of such programs can hard be over emphasized and that too in context to Chittagong Hill Tract Districts.

7. CASE STORIES

As a part of qualitative study, case stories were collected from the study areas. These provide evidence of the situation of awareness or lack thereof in terms of basic healthcare. The case stories disclose some very sad incidences in the lives of hilly people which could otherwise been avoided. Lack of awareness of basic/primary healthcare caused suffering to the community in the study areas. The stories also through light on how improvements are taking place in lives of hilly people with growing awareness on healthcare and hygiene. Some of the stories are given below:

Case Story-1: (Bandarban-1)

Para: Brakhong para Alekkhong Boyangchori	Name: Usama Age: 23 Education: Class IV Profession: Housewife Presently: Do not have any child. Two children were born but both died later.	Husband's Name: Maynum Age : 40 Education: Class III Profession: Agriculture No. of family member: 2

About one and half years ago, Usama's 1st baby died from Pneumonia. During receiving treatment at Bandarban Sadar Hospital, the baby died when the child was only three months old. The child was taken to hospital after two days of becoming sick and she died in the hospital without any treatment. When the sick child was at home, no medical treatment was given. She was taken to a village doctor; an ayurvedic doctor called 'Baiddya' and he prescribed medicines. The child was born with the help of trained midwife at home. Four days before the child died, she suffered from respiratory trouble. When the child's condition became serious, she was taken to hospital but they could not save her life.

. After birth, midwife gave child bath. At that time, no problem was found. In the winter season when the age of baby was about 1 month, she was carried outside in fog during winter and the child caught cold and started coughing. The baby was in a room next to the kitchen. They used wood to prepare food, which created smoke. The baby received Dano milk powder instead of mother's breast milk.

Her second baby also died about two and half months ago. It is assumed that the baby also died from pneumonia. As the baby was not taken to a doctor, the reasons behind the death were not identified. However, one of the health service providers of UNDP who saw the baby said that the baby died from pneumonia. The baby died seven days after birth. Both babies lived in the same room and both were born at the same place. The midwife was also the same. She had a 6-month experienced. After birth, the baby was not sucking mother's breast for milk. After 2 days, the baby suffered from fever and coughing. On 4th day respiratory problem started along with fever. At that time, he was looked after by a quack. His parents gave him quack's medicine. Because of their first child died in hospital they were reluctant to take the second child to hospital for treatment.

The child died without treatment and due to lack of care and superstition of parents that the first child died in hospital and second child would die if taken to hospital.

Usama's two sisters died at an early age. From her childhood, Usama is always sick. All the time she remains under trance. She was under the supervision of a doctor and even after spending .4 to .5 million taka she could not be brought back to normal health. Even her disease could not be diagnosed.

Findings: Case of lack of awareness about neonatal and postnatal care of child. Knowledge about symptoms of pneumonia and its prevention was absent. With proper knowledge of ARI/ Pneumonia children's deaths could be avoided. Timely treatment from doctors at hospital is important instead of relying on quacks and on superstition.

Case Story-2: (Bandarbon-2)

Para: Chupuchui para Noyaptong Boyangchori	Name: Khulbi tong Age: 30 Education: illiterate Profession: Jhum Cultivation	Husband's Name: Noyauogton Age : 40 Education: Class V Profession: Jhum Cultivation No. of family member: 4

Before three days Khulbitong's baby passed away. When the baby was 39 days old a red piercing mark was found at the upper portion of baby's leg. After two days the baby was taken to a quack. The baby passed away on the 2nd day after the quack started his treatment. Before death, the baby was given medicine for 8-10 times. Breast-feeding was totally stopped after the treatment had started. People suggested going for ayurvedic doctor and treatment. Besides this when the condition became bad, because of financial problem the baby could not be taken to a doctor. The money spent for quack was only 50 taka. When baby's mother was pregnant she did not go to any health center for any check up. With the help of midwife, the baby was born at home. However, condition of both mother and baby was sound in that time.

Findings: Case of lack of knowledge about childcare on mother's part and of the community people. Influence of traditional ideas and concepts of treatment and superstition can really be damaging.

Case Story-3: (Bandarbon-3)

Para: Guikhong, Noapotong Bowangchhari	Respondent's Name: jobi Age: 26 years Occupation: farmer Education: has no education Child: two girls	Respondent's Husband Name: konnaram Age: 37 years Occupation: farmer Education: upto 5th class Child: two girls

Jobi's elder daughter is 8 years old and studying in pre-school stage in "para" center. Jobi's younger daughter is just 1 year old. During pregnancy, she received check up at Antaha Para Poribar Kollyan Kendro's Antaha para family planning center. She delivered a child with the help of a trained midwife. After delivery, both the mother and child appeared normal and healthy. However, the child did not take breast feed from her mother. When the child took another women's breast feed, she vomited it.

A few hours later the child's face became red and swelling occurred around the mouth. After death, the child's body turned black. Earlier, they did not take the child to the village doctor or certified doctor. People of the "Para" suggested the parents to take the child to the hospital, but their financial conditions did not support that. Later, it was heard that child's grandmother (father's mother) refused to go as she did not believe in the health service of the hospital.

Findings: Case of lack of knowledge and superstition by people and senior family members. More campaign on essential healthcare is necessary for community people.

Case Story-4: (Bandarbon-4)

Para: Kanaijo Para Noyaptong Boyangchori	Name: Mithuima Age: 35 Education: illiterate Profession: Jhum Cultivation	Husband's Name: Uchimo Age : 43 Education: Class V Profession: Masson No. of family member: 6

Age of Mituima's youngest son is 3 years. Severn days after giving birth to her son she got fever. However, at time of giving birth to baby she was sound. Mithuima delivered her child at home. At the time of delivery, other than her husband and elder daughter (16 years old) nobody else was present at home. After the delivery, mother and baby were sound. However, the baby did not take her mother's breast milk. When Mithuima was pregnant, she did not take TT vaccine and did not carry out regular check up. 7 days after baby was born, one morning at 11 am she developed fever and temperature began to rise with time. Then in the evening, a local village doctor came to their home and gave her an intravenous saline. At this time, Mithuima suffered much and she could not talk. The saline treatment was withdrawn after two-thirds had been completed. Next day, at morning she could not move her body. Her left hand and leg were paralyzed. At that time, an ayurvedic physician treated her by giving herbal medicine and amulet and he advised patient's relatives to maintain the rules/ taboos of hilly people. This way treatment continued. However, there was no improvement and Mithuim started becoming mentally upset day by day. Lack of interest of her husband was main reason to take her in a doctor. However, financial problem was another main reason. Because of lack of resources, Mithuima is now without any treatment.

Findings: Case of lack of healthcare knowledge and blind faith in indigenous treatment by quacks/ ayurvedic doctors. Negligence of family members/husband to take care of family health and superstition are also responsible for Mithuima's present condition.

Case Story-5: (Bandarbon-5)

Para: Kanaijo Para Noyaptong Boyangchori	Name: Chinnu Age: 23 Education: Class III Profession: Jhum Cultivation	Husband's Name: Ebangshu Age : 29 Education: Class IX Profession: Jhum Cultivation No. of family member: 05

When Chinnu was pregnant, she took TT vaccine and regular check up from Poribar Kallyan Kendra. In that time, she did not face any complicacy. With the help of an experienced midwife, the baby was born at the right time. Mother and child both were sound. Baby grew up normally and her parents gave all vaccine. After two years of the baby's birth her mother could understand that he had learning difficulties. The baby was taken to a spiritual teacher. He advised child's parents to feed rice using lily flower and sacrifice animals by the name of god. But those did not work. Now, she is taking treatment from a healer. However, he advised Chinnu to wrap her child with white cloth. The baby was not taken to a doctor. The baby's father is not interested for his son's treatment. Although he cannot talk, the child is able to hear sounds.

Findings: Case of superstition and lack of knowledge about essential primary healthcare. It is a case of negligence of parents, especially father to take care of health of children.

Case Story-6: (Bandarbon-6)

Para: kanaijo Para Noyaptong Boyangchori	Name: Ethuin Age: 22 Education: Class V Profession: Jhum Cultivation	Husband's Name: Mongping Age : 28 Education: Class IX Profession: Jhum Cultivation No. of family member: 03

When Ethuin was pregnant for the first time, she had three checkup visits at the UNDP mobile health clinic. Everything was all right during pregnancy period. She could feel her baby's movement inside her womb. Ethuin's physical condition was sound at that time. She delivered her baby at home. At that time, she was attended by a midwife who had one-week training. Ethuin gave birth to the child after suffering from delivery pain. Because of late delivery, a village doctor brought home saline to give her. After giving saline, she delivered her baby with difficulty. The weight of baby was good. It was approximately 2.5 kg but her skin color was blue. The baby did not cry or move after birth. Village doctor was present there with midwife. However, he did not understand which treatment was necessary for the child. Ethuin did not take five doses of TT vaccine before her child's birth. From discussion with Ethuin it was noted that she did not consult the health center after she had faced complications due to delayed delivery. Her other child, who is now alive, was born 1 year back, after death of her 1st child. The baby had the same problem. However, this time, an experienced health worker from UNDP was present during delivery. Because of adequate care, the baby is now alive and well.

Findings: Knowledge of essential healthcare is necessary and delivery under trained health worker/ hospital is always better than delivery at home under untrained/ half-trained midwife and / or quack/ ayurvedic doctor.

Case Story-7: (Bandarbon-7)

Para: Mongpru Aalekkhong Bowangchhari	Respondent's Name: Thuipru Age: 28years Occupation: Jhum Cultivation Education: has no education Child: one boy, one girl	Respondent's Husband Name: khotheinung Age: 47 years Occupation: Jhum Cultivation Education: has no education Child: one boy, one girl

The two children of Thuipru go to school. The boy is eleven years old and studying in class one. The girl studying in "shishu" class. The boy does not have any attention in his lessons.

Thuipru did not know about iodized salt and its efficacy. She purchased 20 kgs of salts from the local shop for the whole year. The 20 kg's of salt cost 220 taka. She bought it because of low-price. This family uses salt for cooking and eats with meal as a raw (kacha) salt. They were not aware that iodine deficiency could be a major health problem for them. She also did not know that the absence of iodine can decrease the micronutrient supplements and it can be barrier for child's growth.

She attended only once a "para" center meeting. The "para" worker taught everything about the cleanliness, use of sanitary latrine, washing hand after defecation, pregnant mother care, etc. However, the "para" worker did not talk about taking iodized salt. When she went to "para" worker's house, "para" worker was not there. Like other "jhum" farmers, they stay away from the "para" around 6 to 7 months in a year.

This family is ready to use iodized salt for their children's nourishment and further development, but, they do not consume it if it over priced for them.

Findings: This is a lacking of Para Worker. She needs to maintain a checklist of topics that need to be discussed in Para meetings, especially of healthcare and food, including use of iodized salt.

Case Story-8: (Bandarbon-8)

Para: Mongpru Aalekkhong Bowangchhari	Respondents Name: Chitmranu Age: 40 years Occupation: Jhum Cultivation Education: has no education Child: one boy, three girls	Respondent's Husband Name: Unumot Age: 45 years Occupation: Jhum Cultivation Education: has no education Child: one boy, three girls

The two elder daughters of Chitmranu did not go to school. Her third daughter's age is nine and reads in class two. Son is 7 years and reads in class one. This family purchased 25 kgs of salt from the local market for the whole year. They take salts and feed it to their cow. The salt cost Tk.12 per kg. Chitmranu had heard about iodine salt from the "para" worker. She also remembered that someday "para" worker mentioned about a test to look for iodine in salt. Non-Iodized salt becomes purple when lemon is mixed with it. Besides that, "para" worker also advised on other issues but she could not remember it. She also did not know how non- iodized salt affects human body and cell. Therefore, she always purchases low-priced salt from the market.

Chitmranu lost her two daughters at an early age. One day, first daughter suddenly fainted and passed away at the age of five. They could not manage any doctor for her treatment. They could not understand about the reasons for her unexpected death.

Second daughter died of pneumonia within three months after birth. This family appointed a village doctor for her treatment and the baby died within three days. That time they trusted the village doctor more than they trusted the certified doctors. Nowadays, they do not trust on village healing procedure. When their child gets sick, they go to hospital.

Findings: The healthcare knowledge has no alternative. People can lead healthy life by taking services from trained doctors and hospitals and health centers.

Case Story-9 (Rangamati-1)

CASE 1:

Para: Chowdhuri para Union: Gagra Thana: Kaukhali District: Rangamati	**Name : Jita Chakma** Age: 30 Education : SSC Profession: Para worker	Husband's name: Sohel Bikas Age: 35 Education: SSC Profession: Agriculture DFMI: 8000-10000 TK No. of family member: 4

Jita Chakma decided to conceive 2nd time after five years from birth of her 1st child. After conceiving she visited Mother Care Hospital for routine check-up under the supervision of Dr. Lelin Talukder. At that time she took TT-5 vaccine. Under the supervision of Dr. Lelin Talukder, mother and child both were in good condition. As per advice of Dr. Talukder, Jita got admmitted in hospital with 8 months pregnency. She was informed by doctor that tentative date for the birth of new born baby would be between 31.12.2010 to 02.01.2011. On 31.12.2010 Jita managed her bag and bagage to get hospitalized. In the afternoon of 31.12.2010, Jita's delivery pain started and at that time her husband hired a CNG to carry her to hospital. But when they went out, one of her female neighbours said that if she is hospitalized then male doctor may do her operation which is so embarrassing. After this comment Jita's husband went out to bring a midwife. Jita gave birth to a girl child at 12.00 A.M. But the midwife kept Jita's new born baby on the floor without any cloth. Sohel (Jita's husband) told the midwife to cover the new born baby with a cloth, otherwise she could catch cold. But midwife ignored his word. Almost 1 hour later, new born baby died. Midwife escaped after realizing that the new born child had passed away. It was heard later by people that lot of babies died due lack of experience of this particular midwife. Parents of baby thought, reason behind the death was their superstition.

Findings: In order to lead a healthy normal life the people of CHT districts must come out of superstition and must avail healthcare services that are delivered from the healthcare centers/ hospitals.

Case Story-10 (Rangamati-2)

Para: Gainda Union: Gainda Thana: Rajshali District: Rangamati	**Name : Usna Rani Chakma** Age: 36 Education : Class V Profession: Housewife	Husband's name: Chiro Kumar Chama Age: 41 Education: XIII Profession: Day Labourar Name of Child: Sumi Chakma Age: 10 No. of family member: 3

10 years back at the age of 26, Usna Rani became pregnent for the 2nd time. When she was 7 month's pregnant, she was attacked with fever. For treatment she went to village doctor at local Gainda Bazar. Doctor prescribed high powered anti-biotic medicine and two 1000 mg saline as a treatmet to lower down temparature. With prescribed medicine Usna became cured but she felt weak. Since then she was in fear of doctors. This had an impact at time of delivery. During the delivery family members wanted to take her to a doctor but because of her attitude towards doctors she was not interested. A midwife was brought in to their house to help with delivery. At the time of delivery when baby was dragged out from womb, the baby was injured by the midwife's nail. After this incident, there was an infection on the baby's head. The baby was taken to Chittagong Medical College Hospital for treatment. Although the infection was cured the doctor said that due to the infection the baby could be handicapped. Now the baby is 10 years old but he cannot talk or walk. He is handicapped.

Findings: Without proper knowledge of healthcare, people tend to become superstitious very quickly and sometime this becomes reasons for fatal consequences. Such fatal occurrence could have been avoided if Usna Rani had the proper knowledge of pre-natal and post-natal healthcare.

Case Story-11(Rangamati-3)

Para: Noyapara Union: Raikhali Thana: Kaptai District: Rangamati	**Name :Afzal Mia** Age: 48 Profession: Day labourar	Name of Child: Ahmed Age: 8

Before two years, elder son of Afazal Mia was affected by throat disease. Name of his son is Ahmed,who is 8 years old. He took Ahmed to a quack after tracing of throat disease. From there he brought some herbal medicine. Ahmed began to use them. But throat disease increased further. Like this way 6 months passed. But no fruitful result was found. After that, Imam of mosque suggested Afzal to take his son to the hospital. At the end Afzal took his son to Boroishuri health complex and doctor examined him. Doctor reported that Ahmed had throat problem and it happened because of iodine deficiency. By following doctor's advices Ahmed had recoved from his problem. Now he uses idoine salt in his house and can realize the problems that can happen bacause of it.

Findings: Proper and right approach to healtcare can keep people safe and healthy.

Case Story-12 (Rangamati-4)

Para: Noyapara Union: Raikhali Thana: Kaptai District: Rangamati	**Name : Omiuchin Marma** Age: 18 Education: Class V Profession: Housewife	Husband's name: Amendro Marma Age: 25 Education: XII Profession: Day Labourar

When Omiuchin was 13 years old , she eloped with Amendro and got married. But Omiuchin' family didn't accept that. Within 1 year of her married life, she became pregnant. At that time because of poverty she had to climb hill to cut wood. As a result she could not receive any nutrient food and could not visit doctor. After completing 9 months of pregnancy a baby was born with the help of midwife. At the time she could not understand about the gender of her baby because of parts displacement. Baby died after one hour of birth. It is to be noted that Omiuchin didn't receive any TT vaccine during the period of pragnancy because of her immunization phobia. At the end she could realize that because of early marriage and lack of nutrition her baby passed away.

Findings: The story itself says that, 'early marriage and lack of nutrition' are comsequence of lack of knowledge and negligence about healthcare.

Case Story-13(Rangamati-5)

Para: Baromonia Para Union: Chandroghona Thana: Kaptai District: Rangamati	**Name : Mahbub Mia** Education: Illiterate Profession: Day Labourar	Father's name: Abdul Bakkar DMFI: 3200 Taka No. of family members: 05.

Sometimes Mahbub uses open air and jungles for defecation and Urination. He does not know the importance of using sanitary latrine. If any NGO provide him sanitary latrine facilities he will use that sanitary latrine.

Finding: Typical case of lack of wareness and motivation. External support may be necessary for setting up hygeinic sanitary latrine.

Case Story_14 (Khagrachhori-1)
Non Intervention Area

Para: Neya Para Union: Kouyan Ghat Thana: Mohalchari District: Khagrachari	**Name : Reli Chakma** Age: 36 Education: Class IV Profession: Day Labourar	Husband's name: Niharika Chakma DMFI: 3000 Taka No. of family members: 05.

Reli gave birth to a girl child about 22 days ago. Because of superstition she ignored her baby from breast feeding. She didn't know anything about maternal healthcare or child care. Her baby was delivered with the help of midwife at home. At that time she had bleeding. It was late delivery. Due to lack of communication facilities she couldn't be hospitalized. Only walking by foot and motor bike are the transport in this area. There is no pre-school center in this area. Number of family is 37 and polulation is about 165 and number of children who's are three and half years are 18. only chakmas are living there. At the time of pregnancy she didn't do any check-up and listened to words of neighbours. She was not interested to go to doctor. The inhabitants lives below proverty line in this area. She does not know any thing about the immunization system. She thinks that her baby will fall sick and if vaccinated.The area is remote and deprived of many facilities.

Findings: People must come out of superstition to be able to lead healthy life and be able to take services from halthcare centers. The remote ares need to be identified further and healthcare facilities need to be taken to doorsteps of people living there.

Case Story-15(Khagrachhori-2)

Para: Kalo Pahar para Thana: Mohalchari District: Khagrachari	**Name : Surjo Banu** Age: 25 Education: Class I Profession: Housewife	Husband's name: Ali Akbor Profession: Helper of Chader Gari DMFI: 3500 Taka No. of family members: 04.

Now surjo is pregnant for about 8 months. But she doesn't receive any suggestion from doctor and did not visit any health center to get helathcare services till now. In her family delivery has always been done by midwife. Midwife has no training. In this situation she doesn't receive any treatment. To arrive sadar hospital, at first she walk on hilly way about 2 km. Then by "chander gari"(Old Jeep)she can reach there. There is no good health service providing center in her area. The main reasons for not taking treatment is poverty and illness is due to inability to buy nutritious foods. Evironment is not neat and clean around her house. Because of disadvantage of communication, this area is being neglected. This area is out of ICDP project. They are not able to take adequate food regularly. Sometimes they take open salt and sometimes packet salt. They do not use sanitary latrine or wash their hand with soap/ ash after defecation. By birth, they are inhabitants in this area.

Findings: ICDP need to extend their program to new areas where pleople are willing and need extensive healthcare.

Case Story-16 (Khagrachhori-3)

Para: South Mohammad Para Union: Panchari Thana: Panchari District: Khagrachari	**Name : Sabina Akter** Age: 23 Education: Class III Profession: Housewife	Husband's name: Jaitunnesha DMFI: 2500 Taka No. of family members: 03.

Now sabina is pregnant for about 8 months. But she didn't visit any heath centers to receive any healthcare service. Her health condition is not good and she is having nutrition problem. Because she lives below poverty level. Her husband doesn't take any care and are not intersted to have check-ups. She doesn't receive any kind of maternal care or suggestions. There is no way to be hospitalized. She doesn't receive TT vaccine and Iron tablets.

Findings: For poor hilly people free healthcare services need to be planned.

Case Story-17(Khagrachhori-4)

Name : Saidur Mia Age: 50 Education: Illiterate Profession: Day Labourer	Wife's name: Panfur Begum Age: 42 DMFI: 3000 Taka No. of family members: 06.

Saidur Mia does not take iodine salt with his food. All the time he buys open salt from bazar. He thinks all salt are same. Because he thinks to buy salt with high price there is no benefit. He does not know the importance of iodized salt. He doesn't listen anything from others about the importance of iodized salt. There are 35 families in this area . Thre are no sanitary latrine facilities in Saidur's house.

Findings: People need to be motivated more on health and hygiene and on importace of iodized salt and usage of samiltary latrine.

Case Story-18(Khagrachhori-5)

Name : Nurul Islam Age: 55 Education: Illiterate Profession: Agriculture	Wife's name: Panful Begum DMFI: 4000 Taka No. of family members: 03.

Sometimes Nurul Islam uses hanging latrine in open air and uses jungles in case of defecation and urination. He does not know the importance of using sanitary latrine. If any NGO provide him sanitary latrine facilities he will use same. After the Liberation War in 1971 he had come here from Noakhali to live.

Findings: More awarenwss building is required. People need to be motivated about health and hygiene.

Case Story-19(Khagrachhori-6)

Para:Snehomohan karbari Para Union: Logang Thana: Panchari District: Khagrachari	**Name : Susmita Chakma** Age: 28 Education: Illiterate Profession: Housewife	Husband's name: Apon Chakma Profession: Agriculure DMFI: 4000 Taka No. of family members: 05.

Sushmita Chakma does not follow any family planning method. She got married about 1 year 3 months ago. The couple thinks that if they use any family planning method then there could be infected or develop cancer. They have not heard of any other method than condom and pill. This area is disadvantageous area. The population is about 170. Number of children up to the age of three and half years are 17. To arrive Upazila sadar by using "Chander gari" (Old Jeep) and foot it takes more than three hours.

Findings: More awareness building is required amongst people of areas like this.

Overall Findings from Case Stories:

It reveals from the case stories that the CHT district people are still very superstitious. They believe in many supernatural things and miracles that can be caused by 'baiddyas'(local ayurvedic doctors), quacks and so-called religious persons. Therefore, when they fall sick they go to these people instead of going to clinics and hospitals. They are still shy about community people's comments when they sometime take their wives to clinics / hospitals where possibly male doctors could attend. To remove all these, extensive awareness building programs need to be undertaken. In poor populated areas free treatments need to be given. More non-intervention areas need to be covered where people still live under extreme poverty level.

8. Recommendations:

The following recommendations are put forward based on the findings and analysis discussed in the above sections:

1. Expand the program into non-intervention areas also.

2. Include new activities such as tailoring training and other income generating activities and micro-credit financing.
3. Conduct full training of Para workers, especially on training on preparing community action plans for Water & Sanitation and knowledge on first aid, and regular refresher courses at regular intervals.
4. Make provision for regular repair and maintenance of Para center.

5. Regular replacement of damaged preschool materials and install tube well in every Para center to ensure safe drinking water for the students.
6. Enhance Para Workers' remuneration.

7. Increase frequency and type of monitoring the function of Para centers and Para Workers.
8. Hold cluster meetings more frequently and include some more health related issues, such as STD and HIV/AIDS, superstitions with regard to disease and illness, etc.