Assessment of Yearly Geographical Reconnaissance of the Bangladesh Health and Population Sector Programme

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Glossary

ABER	Annual Blood Examination Rate
AHI	Assistant Health Inspector
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BDHS	Bangladesh Demographic and Health Survey
CAR	Contraceptive Acceptance Rate
CBR	Crude Birth Rate
CC	Community Clinic
CDD	Control of Diarrhoeal Diseases
CDR	Crude Death Rate
CMWRA	Currently-married Women of Reproductive Age
CPR	Contraceptive Prevalence Rate
DGHS	Directorate General of Health Services
DPT	Diphtheria, Pertusis and Tetanus
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FGD	Focus-group Discussion
FHC	Family Health Card
FHRP	Family Health Research Project
FPI	Family Planning Inspector
FRO	Field Research Officer
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GR	Geographical Reconnaissance
HA	Health Assistant
HI	Health Inspector
HIU	Health Information Unit
HPSP	Health and Population Sector Programme
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
JL	Jurisdiction Line
MCH-FP	Maternal and Child Health-Family Planning
MEP	Malaria Eradication Programme
MO (FW)	Medical Officer (Family Welfare)
MO (MCH)	Medical Officer (Maternal and Child Health)
MOHFW	Ministry of Health and Family Welfare
NID	National Immunization Day
OPV	Oral Polio Vaccine
ORP	Operations Research Project
PU	Public Utility
SC	Satellite Clinic
TT	Tetanus Toxoid
UFPO	Upazila Family Planning Officer
UH&FPO	Upazila Health and Family Planning Officer
UH&FWC	Union Health and Family Welfare Centre
UHC	Upazila Health Complex
UMIS	Unified Management Information System
WHO	World Health Organization

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Abstract

During the last four decades, a wide range of data on demographic, maternal, child health and other health-related issues has been generated through yearly Geographical Reconnaissance (GR) in Bangladesh. GR is a massive nationwide endeavour of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh. During the early part of 2000, the first nationwide GR Update was conducted using a new record-keeping and reporting system. The Unified Management Information System (UMIS) Unit of the MOHFW, in collaboration with the Operation Research Project (ORP) of ICDDR,B: Centre for Health and Population Research, introduced the new system. The ORP assessed the GR Update 2000 as part of a one-year monitoring of the implementation of the newly-introduced record-keeping and reporting system in 22 upazilas of Bangladesh. Selected child health, reproductive heath, and demographic indicators generated through the GR Update 2000 were compared with data from the longitudinal surveillance system in 5 upazilas and from the nationwide survey to assess the quality and coverage. There were variations in the percentage of children aged less than 5 years and in the coverage of DPT3, measles, and vitamin A. The coverage of DPT3, measles, and vitamin A was higher in the GR 2000 than that of the surveillance and nationwide survey data. Similarly, the variation was large in the proportion of currently-married women of reproductive age (CMWRA) and in the use of family-planning methods. A tendency of higher reporting of contraceptive use in the GR Update 2000 was observed compared to the nationwide survey data. One of the key demographic indicators, crude death rate (CDR) in particular, suffered from gross under-reporting. GR undertaking is a time-consuming endeavour. The voluminous data appeared to be collected only to fulfill the reporting requirement of the national level. Despite opportunities, the GR data were either little used or were not at all used at the local level. The process of reviewing selected key indicators generated through the GR by the local managers should be institutionalized. The local managers need to be adequately oriented to make best use of the data, which is collected and own by them. Some authority should be given to them to make required adjustment in the design of strategies for conducting GR in a better way, which can be used for improving the delivery of Essential Services Package (ESP).

Introduction

The Bangladesh health and population programme has a long history of collecting population-based selected demographic and health-related data, since 1961 by the male Health Assistants (HA) under the then Malaria Eradication Programme (MEP). Under the title of Geographical Reconnaissance (GR), such data have been collected on a yearly basis. The GR, a vital component of the MEP, was a yearly-bound programme (attack ⇨ surveillance ⇨ consolidation) of a zone fulfilling the specific criteria for shifting from one place to another.

Data for the GR Update round were used for comparing activities to measure the achievements of the programme of blood slide collection to detect malaria cases. This generated data on the annual blood examination rate (ABER). The first nationwide GR and baseline malariometric survey was completed between 1961 and 1968 (1). With a rapid increase in the number of blood slides taken from active fever or fever history cases in 1976, the smallpox surveillance network for mass vaccination, including case detection and containment measures, was used for the surveillance of other diseases. Malaria was included in the list of 13 other communicable diseases, and was placed under the special surveillance programme (2). In 1977, the MEP was renamed as Malaria Control Programme, and was integrated with the general health service to form an integrated health service (3). Since then, yearly conduct of population-based GR Update has become a part of the Malaria Control Programme, and has still been continued as a routine activity by the Directorate General of Health Services (DGHS).

The DGHS administers the GR Update, known as GR Round, each year during January-February. It ultimately became an integral part of health service-delivery in Bangladesh. The surveillance network provided a foundation to add a number of vertical programmes of the MOHFW. The Expanded Programme on Immunization (EPI), six-monthly dosing with vitamin A, Control of Diarrhoeal Diseases (CDD), community-level management of acute respiratory infection (ARI), and surveillance of other diseases were gradually added until the launching of the Health and Population Sector Programme (HPSP) in mid-1998.

The operational definition of the GR is:

> A field operation, which through census, mapping and sampling procedures, and supplemented by office work (such as studies, calculations, and tabulations), determines the quality, quantity, location, and means of accessibility of human habitations within a particular area as well as any additional information and data which may be required for successful implementation of the health

programmes, like malaria control and other disease control programmes (3).

Two distinct objectives of the GR Update are (3):

a. To ensure the total coverage of population and households, which include numerous activities. The activities are: count the total number of households in the Jurisdiction Line[1] (JL), recording type of establishment (seasonal or permanent), location of houses in the JL map, numbering each household sequentially, construction type (mud, bamboo, tin, thatch, pucca), number of rooms and verandah in each household, size of sprayable surface area (wall, ceiling, furniture, etc.) per house per capita, low land, plain land and hilly land, type and mode of communication during all time of the year, source of water supply (river/drain/tank/well/tubewell), temperature, rainfall, and humidity.

b. To provide information on selective diseases and the ways the health service-delivery system addresses, the importance and cooperation from the people, generate their interest on preventive and promotive health, and develop a suitable system of public relations and provision of health education.

Achievement of both the objectives involves a fairly heavy task to be carried out during the GR Update. As envisaged in the HPSP, the health and family-planning activities at the upazila level and below have been brought under a unified management, and population-based data are being collected on a yearly basis. The GR Update will ultimately become an important source of population-based data for the MOHFW. The upazila managers, supervisors, and staff also underscore the importance of GR Update, and consider it as take off stage to begin the remaining activities during rest of the year.

After the formal launching of the HPSP, a considerable time was needed to establish a unified management structure for the new service-delivery strategy, address the personnel and financial management issues, revise job descriptions of staff, orient and impart training to staff about the HPSP, and design a new information system to support the delivery of integrated health and family-planning services, known as Essential Services Package (ESP).

The GR Update is also an integral part of the new information system. The Unified Management Information System (UMIS) unit of the DGHS

[1] A smaller subdivided section of a union originally created for election purpose. Locally known as mouza, the JLs are numbered serially within a upazila, and with the use of an upazila map, a village can be located easily once the JL number is known.

introduced a GR Register along with a set of record-keeping and reporting tools in February 2000. The Operations Research Project (ORP) of ICDDR,B: Centre for Health and Population Research assisted the UMIS unit in designing the GR Register along with other record-keeping and reporting tools to address the need of unified management structure at the upazila level and below.

The ORP was entrusted to intensively monitor the implementation of the new record-keeping and reporting system in 22 upazilas of Jessore and Chittagong districts for one year since February 2000. The objectives of this monitoring were to identify the changes needed to make the UMIS tools user-friendly for service providers, supervisors, and managers, to identify the implementation barriers, and to assess to what extent the new system supports in providing quality services to clients.

The paper presents the results of assessment of the GR Update 2000 carried out as part of an intensive monitoring of the implementation of other record-keeping and reporting tools.

The overall objective of this assessment was to examine the operational aspects of the GR Update, and also to examine the quality and extent of use of data generated through the GR at various levels. The specific objectives of the study were to:

- Assess how the GR Update 2000 was conducted
- Compare selected data generated through the GR Update 2000 with data generated through other sources
- Involve staff to complete the GR Update 2000
- Use GR data at the local level in planning and monitoring

Materials and Methods

A number of methodologies were employed for this assessment. The ORP deployed nine Field Research Officers (FROs) to monitor all activities relating to the implementation of the new system in both the districts. During February-July 2000, the FROs observed the activities of the female Family Welfare Assistants (FWAs) and HAs during the GR Update 2000. They used a monitoring tool to record the activities performed by the HAs and FWAs during the GR Update. In-depth interviews of the primary supervisors of FWAs and HAs and focus-group discussions (FGD) with the FWAs and HAs both independently and jointly were also conducted. An open-ended questionnaire was administered to the selected supervisors of FWAs and HAs to collect data on the use of GR data for operational planning.

Selected child health, reproductive health and demographic indicators, generated through the GR Update 2000, were compared with the data from the longitudinal surveillance system administered by the ICDDR,B at Mirsarai and Satkania of Chittagong district (4), Matlab of Chandpur district (5) in Chittagong division, and Abhoynagar and Keshobpur of Jessore district in Khulna division. Part of Matlab, is known as maternal and child health-family planning (MCH-FP) area and the remaining area is known as comparison area with normal government programme. The ICDDR,B also maintains a longitudinal surveillance system in the comparison area.

Other relevant literature with information on health and family planning-related issues in Bangladesh were also reviewed.

Results

In the following section, an attempt has been made to present the entire procedure of GR Update 2000. In the subsequent section, the selected indicators, generated through GR Update, have been compared with different surveillance and survey data.

GR Update 2000

Under the unified management structure, the FWAs and HAs conducted the first nationwide GR Update 2000. The process of carrying out the GR Update by the FWAs and HAs was not clearly spelled out in their job descriptions (Appendix 1) released in December 1999. The process of carrying out the GR Update by a GR squad, consisted of HAs and FWAs, has been described in another official circular (Appendix 2) issued during mid-January 2000. The circular indicated the use of new GR Register (Appendix 3) developed and approved by the UMIS Implementation Task Force (Appendix 4). Due to some reasons, the GR Register could not be provided nationwide. In absence of the GR Register, the prototype GR format was sent to all the upazilas with an instruction to print them locally by the UMIS unit. A users' guideline, which elaborates the procedure of data collection, recording of collected data in respective sections of the GR Register, and the compilation and preparation of reports, was also circulated to the concern staff (6). Except in Matlab, the remaining upazilas in this study received the new GR Register, provided by the ORP.

In addition to the prototype GR format, required funds were sent to the disposal of Upazila Health and Family Planning Officer (UH&FPO) to arrange coal-tar, brush for numbering households, and other stationeries to update the mouza map (Appendix 5). Initially, there was a confusion among the upazila managers and staff as to when to begin and which system is to be followed for

the GR Update. In the meantime, the GR Round for 2000 was started in many upazilas following the previous system. There was no difference in the process of carrying out GR with the previous system. The most notable differences, however, were: introduction of a new GR Register with 16 major and several sub-indicators [Appendix 6], distribution of a Family Health Card (FHC) to every household, and formation of a GR squad as directed by the national level.

Although both FWAs and HAs have uniform job descriptions, the GR Update is more familiar to the HAs than the FWAs as the HAs are involved with this activity since the beginning of their employment. However, this was entirely a new subject for the FWAs, previously they had different work unit and work schedule. The following activities were included during the GR Update:

- Each household should be numbered with coal-tar
- The first household of a village should contain the first JL number and name, ward[2] number, union[3] number, name and block number
- By indicating with an arrow sign and proceeding number, the movement from one house to another should be indicated
- The first and last households of a village should contain the starting and the ending signs written clearly
- The JL number and name, and block number should be given to every 50th household
- The JL map should be prepared or updated simultaneously after the numbering of each household
- Population and other data should be updated correctly
- Households/institutions should be indicated for public utility, etc.

There was confusion about whether the previously-used Daily Mouza-wise GR forms, known as KA-1, or new GR Register, were to be used for the GR activities. The nature of confusion was reflected in an interview with one HA and one Health Inspector (HI) by the ORP staff during middle part of the GR Update 2000, and is presented below.

[2] A division of a union with an average population of 8,000-9,000.
[3] An administrative unit runs by the local government below upazila level with an average population of 25,000-30,000.

Interview with a HA

? *Have you completed the GR Round in your area?*

🗣 *Yes*

? *When did you start the GR Round?*

🗣 *February 2000*

? *Did you use the GR Register provided by the UMIS Unit?*

🗣 *Yes, but we made some modifications*

? *Why modifications were required?*

🗣 *As instructed by the UH&FPO, we started activities relating to the GR Update using the old GR Form (KA-1). After one month, we were instructed to use the GR Register that was in short supply for each GR squad. So, the local authority printed the GR Register locally, and added few columns for our own use*

? *Would you restart the GR Update using the new GR Register once again?*

🗣 *Yes*

The HIs are the most experienced supervisors having years of their involvement in the GR Update activities. Because of their long experience, they are often consulted by the UH&FPO while undertaking any large-scale endeavour, including GR Update. During the interview conducted by the ORP staff, the HIs reported that the GR activities now did not receive adequate attention from any level. Undertaking the GR Update requires logistics, such as forms, coal-tar, brush, and stationeries, which should reach in time to conduct such a large-scale endeavour. But the same mistakes are repeated on a regular basis. The interview with one HI is presented below.

Interview with a HI

? *Have you completed the GR Update in your upazila?*

🗣 *Yes*

? *When did you start the GR Round?*

🗣 *January 2000*

? *Did you use the GR Register?*

🗣 *No, we started with the old GR Form (KA-1). After the completion of the GR Update of 50% of the households, we started using a GR Register from mid-February*

contd...

Interview with a HI *(contd.)*
? *Would you restart the GR Update using the new GR Register from the first household of the mouza?*
🗣 *Not exactly*
? *What will you do?*
🗣 *We will transfer the collected data from the GR Form (KA-1) to the GR Register*
? *But there are differences between the two systems.*
🗣 *This is not a big problem. Our staff will manage it by copying from the GR Form (KA-1)*
? *How would you collect data relating to family planning?*
🗣 *We will copy from the FWA Register*

The interview with one HA and one HI adequately reflects the level of their seriousness about the GR activities, which is likely to have an impact on the quality of data.

Despite the confusion about the use of new record-keeping tools, the HAs followed the previous practice of the GR Update. Both FWAs and HAs started from southwestern part of a mouza, proceeded in a jig-jag fashion, numbered households mostly on top of door frame with coal-tar, and collected population-related data mostly from adult members of the households. While filling in the introductory section of the FHC, the FWAs distributed the card to every household, and collected data on the use of family-planning methods from the households.

The importance of supervision and systematic monitoring of such a large-scale data-collection activities cannot be seen in isolation. The revised job descriptions of respective supervisors lack explicit explanation of supervisory functions to be performed by the supervisors of different tires during the GR Update (7). According to service-delivery modality currently implemented under the HPSP, the Medical Officer, MCH (MO-MCH) is the head of the field services unit of an upazila. However, the MO-Family Welfare (FW) or an authorized official is the primary supervisor of HAs and FWAs. The circular describing the process of carrying out the GR (Appendix 2) indicated about the formation of a separate team consisting of upazila and district managers to supervise the GR activities. Observations and FGDs with the HAs and FWAs revealed that, in all the upazilas, the concerned officials did not adequately supervise the GR activities. Prior to the launching of HPSP, both Assistant Health Inspector (AHI) and Family Planning Inspector (FPI) were the primary supervisors of HAs and FWAs respectively. According to the new job descriptions released by the MOHFW in December 1999, they are no longer their direct supervisors (7). However, the “Guidelines on Operation, Management and Functioning of

Community Clinic" released in October 2000 by the MOHFW indicated about the supportive supervisory responsibility of both AHIs and FPIs. Only during the scheduled monitoring visits of FROs of ICDDR,B, both AHIs and FPIs accompanied them to the field. Nevertheless, both AHIs and FPIs were entrusted to supervise the activities of GR squad during the GR Round and to compile a union report based on the Mouzawise Geographical Reconnaissance (GR) Report of ward/community clinic (GR Report Form 1) (Appendix 7) and Yearly Morbidity Report of ward/community clinic (Morbidity Report Form 1) (Appendix 8) received from the ward level to prepare the ward/community clinicwise Geographical Reconnaissance (GR) Report of union (GR Report Form 2) (Appendix 9) and Morbidity Report Form No. 2 (Appendix 10). Based on the reports received from the AHIs and FPIs of different unions, the assigned HIs are supposed to compile the unionwise Geographical Reconnaissance (GR) Report of thana (GR Report Form 3) (Appendix 11) and Yearly Morbidity Report of thana (Morbidity Report Form 3) (Appendix 12) for the upazilas. They are also responsible for sending a copy of each report to the Line Director, UMIS unit, through the UH&FPO.

Since the GR Update may continue in the coming years, and will generate population-based data on a yearly basis, it is necessary to examine the quality of data being generated. Because as soon as the system of providing services from Community Clinics (CCs) by HAs and FWAs is established, an alternative mechanism may be required to conduct the GR Update in its present form. Despite variation in the number of unions in each upazila, 4-6 months were needed to complete the GR Update by FWAs and HAs in all the study upazilas.

In the following section, data on selected child health, reproductive health, and demographic indicators generated from the GR Update and from the longitudinal surveillance system have been examined. The ICDDR,B has a long-term presence, and has implemented numerous MCH-FP-related interventions for more than a decade in one part of Matlab. As a result, there has been a considerable impact on many fertility and mortality indicators in the MCH-FP area. In some cases, there are large variations between the GR and surveillance data. Reasons for such variations could be due to the difference in data-collection methodologies (e.g. short interval vs longer interval), the problem of recall bias, lack of proper training on data-collection procedure, and inadequate supervision. However, the completeness and quality of GR data are not immune from questions.

Child health

Children aged less than 5 years are the important target group for ESP. Status of coverage with full dose of immunization and coverage of vitamin A is a commonly-used indicator of child health. The child-health indicators examined included the percentage distribution of children aged less than 5 years and the percentage of children aged 12-23 months who had received a DPT3 dose, measles vaccine, and vitamin A dose.

The percentage of children aged less than 5 years reported in the GR Update 2000 of Mirsarai, Abhoynagar, and Keshobpur was quite close to and almost identical with the national data (8) (Fig. 1). The surveillance estimates (4) for these upazilas were slightly lower than the GR Update 2000, while that of MCH-FP area of Matlab was almost identical with the national estimate. On the contrary, the percentage of children aged less than 5 years was 12.2% in the comparison area, not shown in the figure. Both GR Update 2000 and surveillance data for Satkania were almost similar but were higher than the national data by about 2 percentage points. Variation of the GR Update 2000 data with the surveillance and the national data for the Matlab MCH-FP area was 3.5 percentage points.

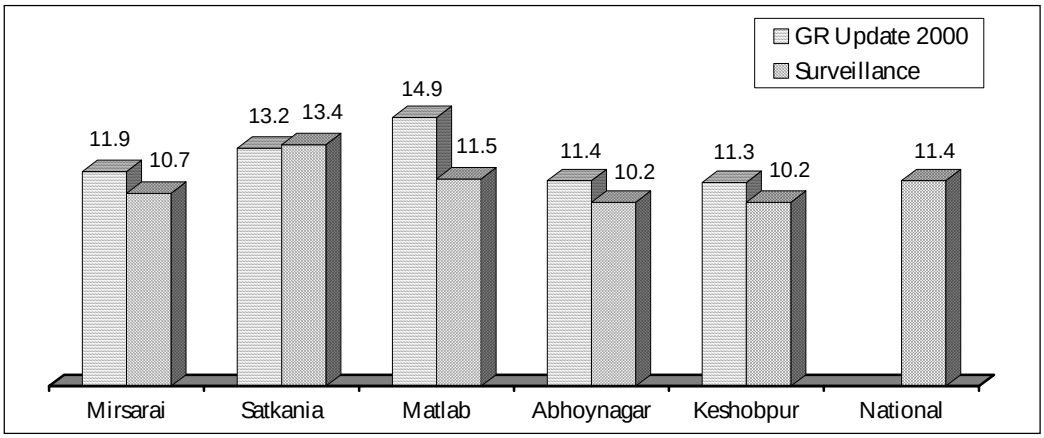


Fig. 1. Percentage of children, aged less than 5 years, reported in GR Update 2000 and surveillance

The national coverage of DPT3 is 72.1%, whereas it is 78.1% in Chittagong division and 80.8% in Khulna division (9). Except Matlab, the coverage of DPT3 reported in the GR Update 2000 for other upazilas was above 90%. The coverage of DPT3 reported in the surveillance data ranged from 81.1% to 96.9%, and was considerably higher than the national data (Table 1). Interestingly, the coverage of DPT3 for Matlab reported in the GR Update 2000 was lower than that of the surveillance data.

Table 1. Percentage of children, aged 12-23 months, who had received DPT3 doses reported in GR Update 2000 and surveillance

Source	Upazila					
	Mirsarai	Satkania	Matlab	Abhoynagar	Keshobpur	BDHS* 1999-2000
GR Update 2000	99.9	93.7	81.8	99.9	99.5	
Surveillance	84.3	81.1	96.9	89.3	85.3	72.1

* BDHS=Bangladesh Demographic and Health Survey

The overall coverage of measles is 70.8% in Bangladesh, whereas it is 77.2% in Chittagong division and 81.0% in Khulna division (9). Except Matlab, the coverage of measles vaccine reported in the GR Update 2000 for all other upazilas was higher by 20 percentage points than that of the Bangladesh Health and Demographic Survey (BDHS) 1999-2000 data. The reporting difference is about 15 percentage points for Matlab. In fact, the coverage of measles vaccine reported in the surveillance data was higher than that reported in the GR Update 2000 for Matlab (Fig. 2). The gap between the BDHS 1999-2000 and the surveillance data for Satkania was lower than all other upazilas.

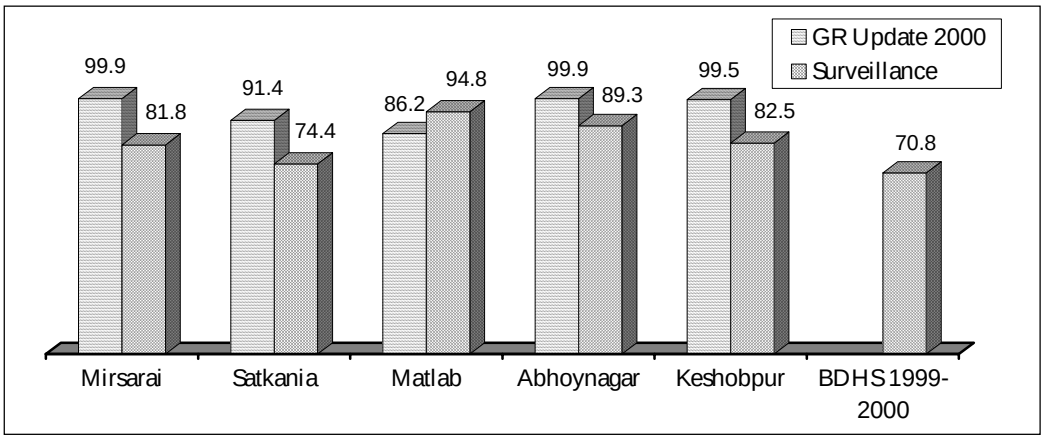


Fig. 2. Percentage of children, aged 12-23 months, who had received measles vaccine reported in GR Update 2000 and surveillance

The overall coverage of vitamin A distribution is 73.3% in Bangladesh. The coverage is 68.9% in Chittagong division and 76.7% in Khulna division (9). The coverage of vitamin A distribution reported in the GR Update 2000 for all the upazilas either exceeded or was close to 100%, except Keshobpur where it was 91%. It was observed that the standard instruction was not properly followed to record this information in this section. This section of the report was prepared with data available in their respective EPI Register of the previous system. The coverage of vitamin A distribution in Satkania and Abhoynagar

reported in the surveillance data was nearly close to the BDHS 1999-2000 data. According to the surveillance data for Keshobpur and Mirsarai, the coverage was lower than that of the national data but was higher in Matlab (Table 2).

Table 2. Percentage of children, aged less than 5 years, who had received vitamin A doses during past one year reported in GR Update 2000 and surveillance

Source	Upazila					
	Mirsarai	Satkania	Matlab	Abhoynagar	Keshobpur	BDHS 1999-2000
GR Update 2000	99.9	124.0	104.0	117.0	90.7	
Surveillance	69.9	71.9	82.1	72.6	63.5	73.3

Reproductive health

The indicators used under reproductive health included the percentage of CMWRA, coverage of TT, pregnancy prevalence, place of delivery, percentage of CMWRA using family-planning methods, and sources of modern contraceptive methods.

The CMWRAs are an important group for various interventions under the reproductive health programme. It is estimated that about one-fifth of the total population of Bangladesh fall in the 15-49-year age group. There are wide variations between the GR Update 2000 and the surveillance data for all the upazilas (Fig. 3). These wide variations could be due to sampling methodology and sample size (4). The variations between the GR Update 2000 and the national data (8) are not large for other upazilas, except for the Matlab MCH-FP area (5), and Satkania.

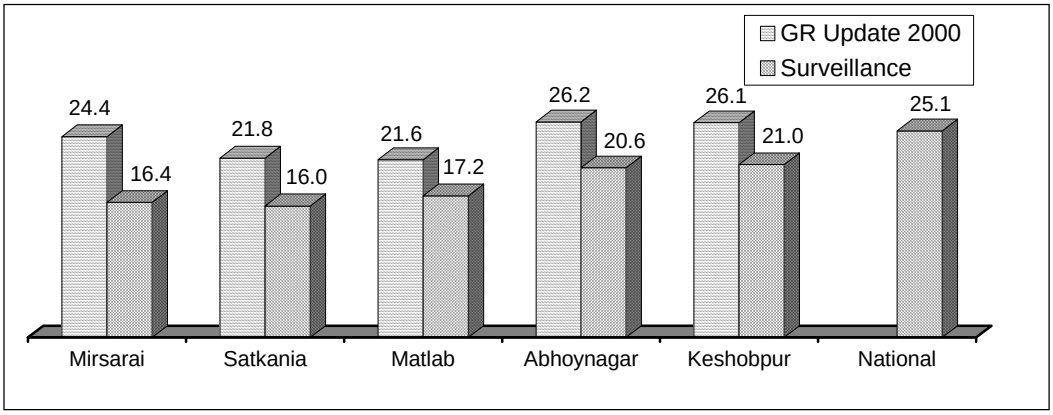


Fig. 3. Percentage of currently married woman of reproductive age reported in GR Update 2000 and surveillance

Data on pregnancy prevalence during the GR Update 2000 was collected by asking whether anyone in the household was currently pregnant. The chance of under-reporting cannot be ruled out here, because pregnancy during first trimester may not be reported due to uncertainty on the part of women.

The rate of pregnancy prevalence at the national level reported in BDHS is 7.8% of the total CMWRA (9). The pregnancy prevalence between the GR Update 2000 and the surveillance data was compared for all the study upazilas (Fig. 4). Other than Matlab, the rate of pregnancy prevalence reported in the GR Update 2000 ranged from 5.3% to 8.9%. In Matlab, it was 13.4%. The rate is 10.3% in the surveillance data for Matlab MCH-FP (5).

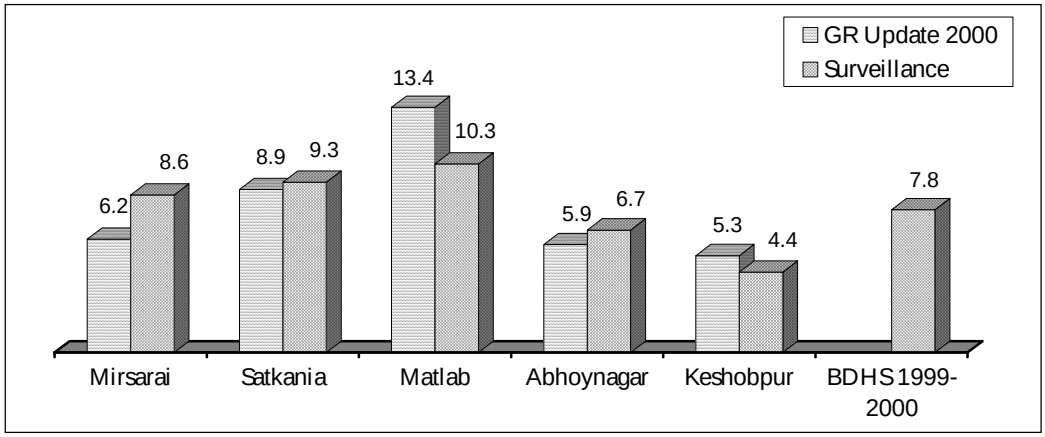


Fig. 4. Percentage of pregnant women reported in GR Update 2000 and surveillance

The overall coverage of TT2+ doses is 63.7% in Bangladesh, whereas it is 62.8% in Chittagong division and 65.5 in Khulna division (9). The figure-5 shows that the coverage of TT2+ doses reported in the GR update 2000 for Mirsarai, Satkania, and Keshobpur upazilas were comparable to the BDHS 1999-2000 data. Surprisingly, the coverage of TT2+ doses reported in the GR Update 2000 in Abhoynagar upazila was higher by about 17 percent, while it was lower by about 23 percent in Matlab upazila than that of BDHS 1999-2000.

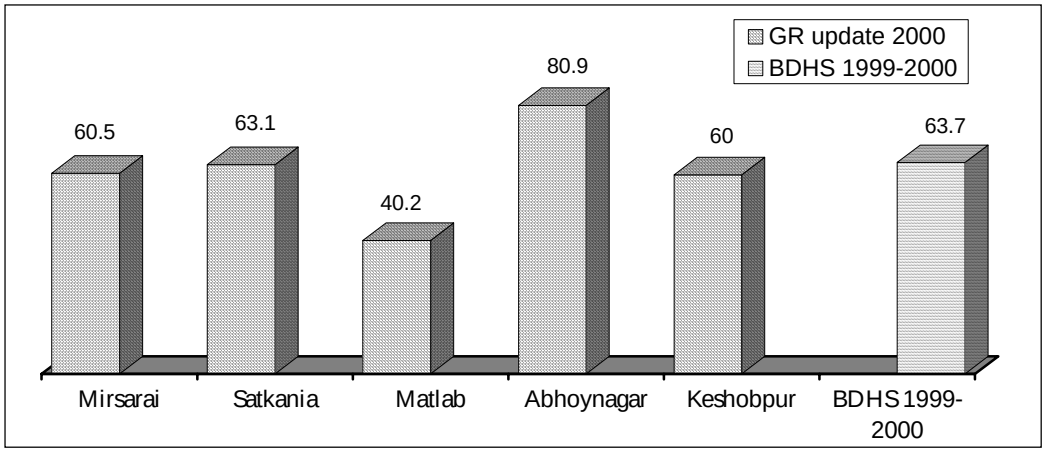


Fig. 5. Percentage of women received TT2+ doses reported in GR Update 2000 and BDHS 1999-2000

The BDHS 1999-2000 reports that 12.1% of deliveries are medically assisted (by doctor/nurse/midwife/family welfare visitor) in Bangladesh (9). The BDHS uses the term "medically assisted" delivery, while the surveillance data for Matlab and the GR data used the term "institutional delivery." Both the terms imply whether the services of trained providers were used for delivery. The percentage of medically-assisted deliveries at the institutional level reported in the GR Update 2000 for all upazilas ranged from 4% to 11%. The percentages of medically-assisted deliveries reported in the survey data (10) for Mirsarai and Abhoynagar are close to the BDHS 1999-2000 data (Fig. 6).

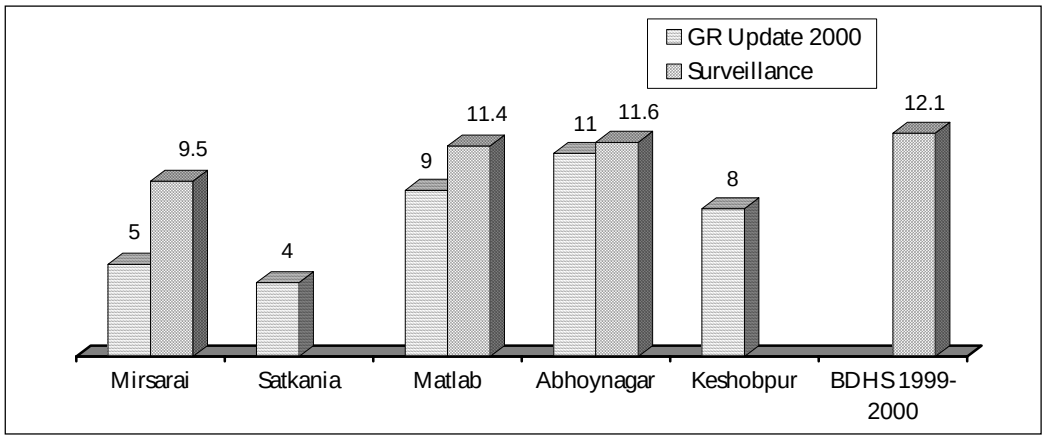


Fig. 6. Percentage of deliveries attended by trained providers reported in GR Update 2000 and surveillance

Contraceptive prevalence rate (CPR) is one of most widely-used indicators in Bangladesh. CPR was defined as the proportion of CMWRA who reported that they or their husbands were using a family-planning method at the time of interview. All CMWRA were asked about the status of current use of family-planning methods during the GR Update 2000. Table 3 shows that the CPR varied from as low as 38.1% to as high as 63.8% reported in the GR Update 2000. The CPR reported in the surveillance data also varied from as low as 29.5% to as high as 69.9%. Other than Mirsarai and Satkania, the CPR reported in the surveillance data was either higher or close to the BDHS level in all the upazilas. These two upazilas are located in Chittagong division, which is a low-performing area.

The nationwide survey revealed that the non-clinical contraceptive methods, such as oral pill and condom, was more used than clinical methods in Bangladesh. Except Abhoynagar, the use of non-clinical methods reported in the GR Update 2000 was higher than that of clinical methods, such as injectables, intra-uterine devices (IUD), norplant, male and female sterilization, in all other upazilas. In Abhoynagar, this was just equal (Table 3). The use of clinical methods was higher in both Matlab and Abhoynagar compared to other study upazilas as revealed in the surveillance data. Interestingly, the gap between the GR Update 2000 and the surveillance data on the use of clinical and non-clinical methods was not large, it was rather quite similar, except for Matlab. This issue needs some investigation. On the other hand, the proportions of users of both non-clinical and clinical methods did not match with the national data. It is assumed that the MCH-FP-related interventions carried by the ICDDR,B could have influenced the high rate of use of clinical contraception in Matlab.

Table 3. Percent distribution of currently married woman of reproductive age (CMWRA) using family-planning methods reported in GR Update 2000 and surveillance

Method	Mirsarai		Satkania		Matlab		Abhoynagar		Keshobpur		BDHS 1999-2000
	GR	Surv	GR	Surv	GR	Surv	GR	Surv	GR	Surv	
Any method	48.9	42.8	38.1	29.5	63.0	69.9	63.8	59.0	61.5	52.1	53.8
Non-clinical methods	28.2	20.1	25.6	16.2	33.9	24.6	32.2	23.7	39.6	26.2	27.3
Clinical methods	20.7	19.8	12.5	11.4	29.1	43.0	31.6	32.6	21.9	20.1	16.2
Traditional methods	NA	2.9	NA	1.9	NA	2.3	NA	2.7	NA	5.8	10.3
Total eligible couple	65,835	5,535	55,301	2,055	79,669	19,118	45,275	3,510	48,448	1,893	9,720

GR = Geographical Reconnaissance; Surv = Surveillance; NA = Not available

Sources of modern contraceptive methods were also used as an indicator to assess the quality of programme performance, dependency on government sources, and the extent of mobility of women. The government was still the main source of modern contraceptives, except Matlab where the ICDDR,B is the sole source (Fig. 7).

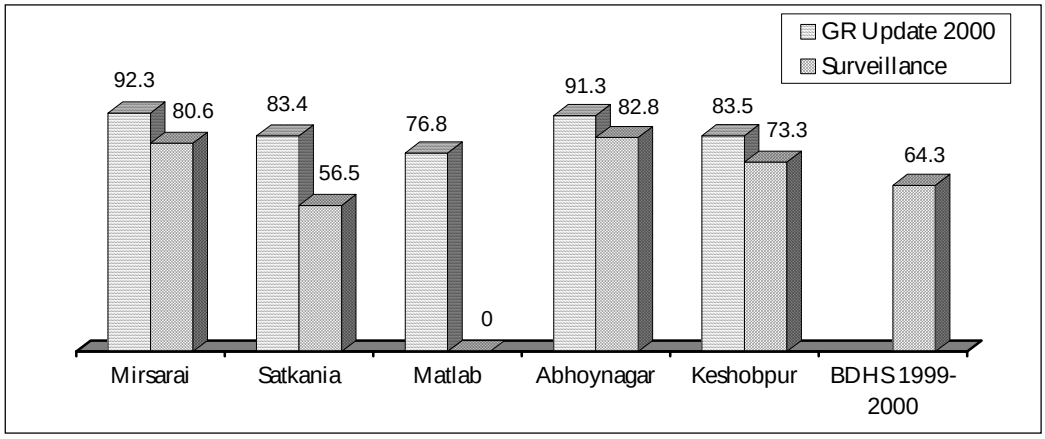


Fig. 7. Percent distribution of current users of modern contraceptive methods who received supply from GoB sources reported in GR Update 2000 and surveillance

Demographic indicators

The demographic indicators compared here include crude birth rate (CBR), crude death rate (CDR), and population growth rate. Other demographic rates were not calculated due to the problem of incompleteness of numerators. The last one-year was the reference period for recording vital events, but application of the reference period is unlikely to be immune from the problem of accuracy in recording and reporting. Despite the ambiguity of the reference period, data on the total number of births appeared to have been collected well.

Although the estimated CBR for Bangladesh is 22.4 (11), the CBR generated through the GR Update 2000 in all the study upazilas ranged from 20.4 to 26.5 (Fig. 8), and the CBR reported in the surveillance data also ranged from 20.5 to 28.7. Both Satkania and Matlab had an identical CBR as reported in the GR Update 2000 and surveillance data, which is higher than the estimated national data (Fig. 8).

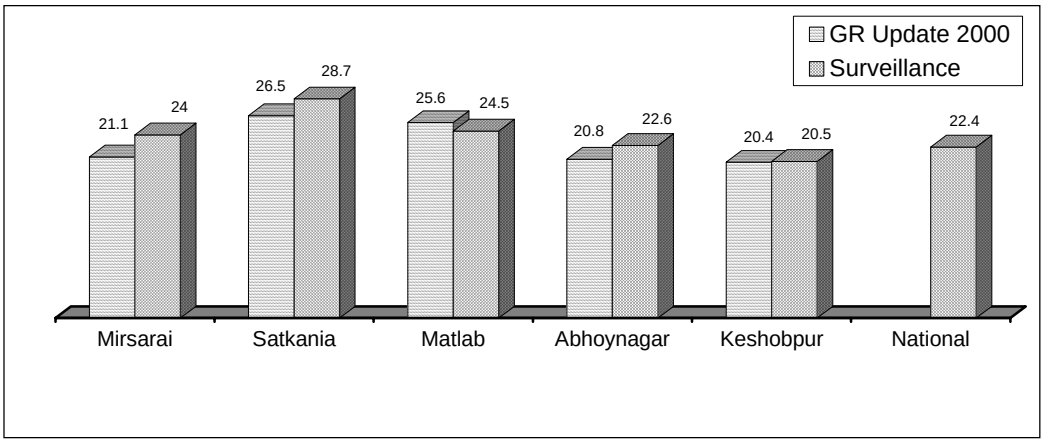


Fig. 8. Crude birth rate reported in GR Update 2000 and surveillance

All deaths occurred in 1999 were recorded during the GR Update 2000. Apparently, the pattern of CDR reported in the GR Update 2000 was similar for all the study upazilas (Fig. 9). The reference period of last one year and its application seem to be a problem, because the CDR for all the upazilas was 50% lower than the CDR reported in the surveillance and national (11) data. This problem could have been avoided with some supervisory efforts.

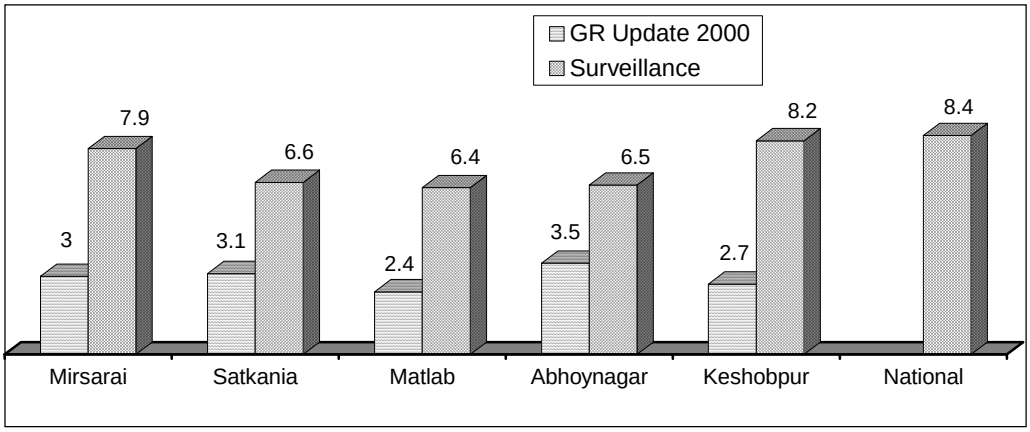
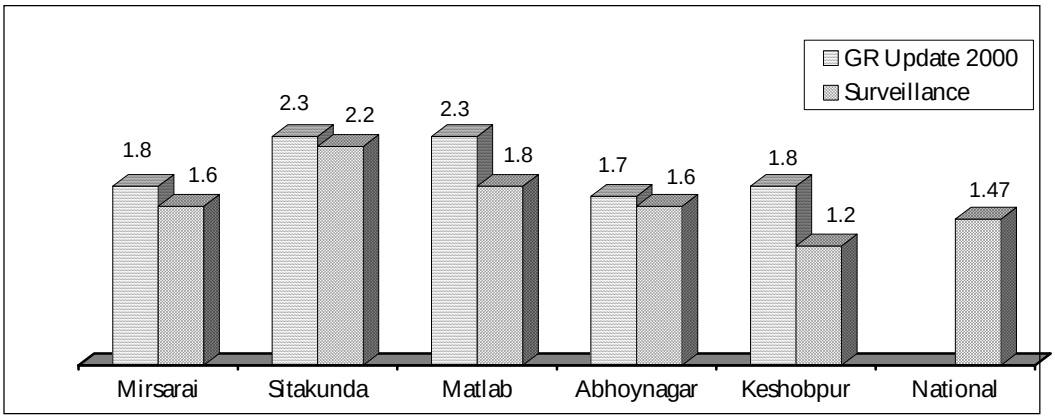


Fig. 9. Crude death rate reported in GR Update 2000 and surveillance

As per the census 2001, the population growth rate is 1.47% (12), which is close to that of all the study upazilas reported in the GR Update 2000 and presented in Fig. 10. No difference in the growth rate was observed due to potential under-reporting of both births and deaths in all the upazilas.



Time spent for GR Update 2000

Time spent for the GR Update activities has an important programmatic implication in the future. As soon the system of providing services from CCs is established, the HAs and FWAs are likely to be involved full-time in offering services. In that situation, the question is who will carry out the GR Update-related activities and how needs to be decided. The involvement of staff time, thus, needs to be reviewed critically. The advance tour programmes of HAs/FWAs of five upazilas from February to July 2000 were reviewed to assess the number of working days scheduled to be spent for the GR Update 2000. Figure 11 shows that 45% of the planned time was spent for the GR Update, and the rest of the planned time was spent for other assigned activities, such as to attend immunization sessions, satellite clinics (SCs), meetings, and collection of logistics and salary from the upazila level.

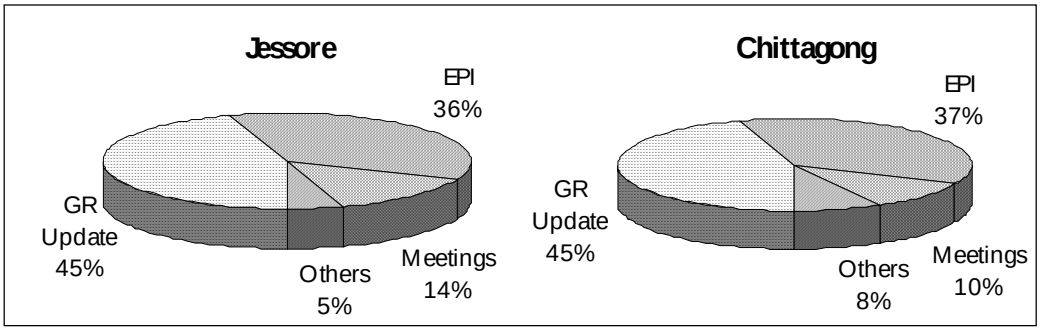


Fig. 11. Percentage of time spent by Health Assistant for GR Update and other activities during GR Update 2000 (February-July 2000)

Use of Geographical Reconnaissance Data

Surveys were conducted to assess the health status and use of health services, and to establish some health-related indicators after the liberation of Bangladesh. It is not clearly known whether or not data collected through the GR were analyzed and used. Of the 16 major selected indicators (Appendix 6), the HAs and FWAs used very few of them. Both HAs and FWAs prepared their advance tour programmes using the household numbers to indicate the total number of households to be visited on each work day, number of children aged less than one year to bring them under EPI coverage, and number of children aged less than 5 years to place indent for vaccines for National Immunization Days (NIDs). In the past, the surveillance was carried out to identify the malaria cases by collecting blood slides and providing presumptive treatment, record identification numbers on the blood slides collected from suspected malaria cases, plan and perform six-monthly vitamin A dosing, and community mobilization for immunization.

On the other hand, a GR map was drawn for each and every year for each mouza by the HAs plotting the dwelling households, public utilities, such as mosques, temples, educational institutions, communication networks, shops, tanks, and paddy fields, etc., which were seldom used for any purpose and kept under the disposal of the respective HI. The potential use of the mouza map to strengthen the geographical information system (GIS) to identify the gaps and overlaps in improving health services are yet to be explored due to lack of expertise of the concerned officials. Besides, the existing infrastructure at the upazila level does not permit to embark on this kind of venture.

The Health Information Unit (HIU) of DGHS, published the “Bangladesh Health Profile 1977” with brief description and performance of various health programmes, health situation, including both prevalence and incidence of various diseases, and status of health facilities. The HIU published the national health statistical report titled “Bangladesh Health Services Report” first in 1985 and then in 1989. Its publication was discontinued in 1991 due to financial constraint. In 1992, the HIU published another report titled “Health Profile”, and then in 1996, published the “Bangladesh Health Bulletin” with assistance from the WHO. The Bangladesh Health Bulletin did not include any analysis of the GR data for any corresponding year other than the data on the disease profiles based on the health facilities.

During the interview, the HAs and AHIs, could not precisely tell about the use of GR data but HIs could mention the use of GR data for vaccination and vitamin A round. The upazila managers used partial data to prepare a display board titled “Basic Information of the Upazila” using numbers and charts to reflect the total number of dwelling households, public utilities, and age-specific population for their chambers.

There was no real use of the GR data at the upazila level, because no feedbacks have been received from the national level. The UH&FPOs mentioned about lack of any review of the GR data at the district level.

Lessons Learned

Being the key operational mangers of rural health service-delivery, the upazila managers have limited opportunity to assess the healthcare-delivery coverage of population, achievement of programme, and service objectives and targets in their respective upazila from the nationwide survey data. The quality of data generated through the GR Update and its usefulness at the operational level from the upazila and below is yet to be assessed. Limited or no use of the GR data is evident from the fact that the targets for EPI coverage are fixed based on the EPI Register of the particular outreach centre, and the target for recruitment of new family-planning acceptors is determined at the national level. Data were not reviewed either at the local level or at the district level to compare the progress or achievements among and between the upazilas. Moreover, the findings of the monitoring revealed that the managers and supervisors at the upazila level did not pay proper attention to ensure the quality of data collected by the service providers. There were difficulties to begin the GR Update activities timely, because the required logistics and allotted funds did not reach on time.

Data collection through the GR may be continued in this manner in the future because of the instruction from the national level. The data were sent to the national level as part of the regular reporting system. Despite the problem of quality, there is a potential to use the data, provided some authority is given to the managers to ensure its increased use. The basic question is what are the key indicators the operational mangers should know to monitor their programme. There is a need to assess whether some selected ESP indicators can be collected quickly.

Recommendations

Continuation of large-scale data-collection endeavours, like the yearly GR Update, requires more objective assessment. Time implication of undertaking the GR in the current form needs to be reviewed to improve the quality of data. There is also a need to examine whether the GR can be conducted quickly without changing the current system. The potential of using already-tested Rapid Assessment Methodology by other agencies can be combined with large-scale data-collection endeavour, like the yearly GR Update, for monitoring the health and demographic levels and trends at the local level. This will reduce a considerable time of a large number of human resources and the upazila mangers will also be able to make their own assessment of the status of the programme managed and administered by them on behalf of the national level. The process should begin immediately. Otherwise, the yearly GR will become a yearly ritual.

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Appendix 1

Job Descriptions of Health Assistant and Family Welfare Assistant

According to new job descriptions of HAs and FWAs, two types of functions are to be performed at CC and doorstep. The following services are to be offered by HA/FWA at CC, SC, and domicilliary level.

CC/SC

1. Run CC/SC involving the community group to provide ESP successfully.
2. Fix up the working day and schedule of CC through discussion with the community group.
3. Register all clients at the CC.
4. Provide quality services to patients.
5. Register pregnant women and record EDD.
6. Provide services to mothers during antenatal, delivery and postnatal periods and also to provide services to neonatal baby.
7. Distribute Vitamin A capsule to mothers (within 2 weeks of delivery) and children (attacked by malnutrition, prolonged diarrhoea, and measles).
8. Diagnose anaemic women and adolescent girls, and provide treatment.
9. Provide immunization to children (6 dose).
10. Identify and manage children with nightblindness.
11. Distribute medicines as per prescription of higher-level hospital/clinics to patients with iodine deficiency, worms, ARI, TB, leprosy, malaria, and scabies.
12. Treat diarrhoea patients with ORS.
13. Provide diarrhoea treatment, and assist them to prepare ORS during domicilliary visits.
14. Ensure regular supply and distribution of temporary family-planning methods, e.g. condom, pill, etc.
15. Assist FWV at UHFWC and CC/SC regarding insertion of IUD and Injectables.
16. Provide second dose injectables by trained FWA properly.
17. Distribute medicines according to symptoms to general patients with injury, fever, pain, asthma, skin disease and problems with eye, teeth and ear.
18. Organize group counseling to patients coming to hospitals about the benefit of healthy life, cleanliness, sanitation (environmental health, safe-drinking

water and sanitation), balanced diet, prevention of diseases through immunization. Protection of worm, advantages of breast-feeding, prevention of diarrhoea, mass awareness on malnutrition, usefulness of family-planning methods. BCC will be provided by HA/FWA.

19. Provide counselling to patients on RTI, STD, HIV, and AIDS.
20. Provide suggestion to give breastmilk at least up to six months to children.
21. Create awareness building on sexuality, safe sex, and nutritional food for girls and women.
22. Provide assistance and counselling to the aged people on leading good health.
23. Implement health-education programme at the ward/community level.
24. Provide counselling regarding food habit to protect malnutrition.
25. Take necessary steps to prevent communicable and infectious diseases when needed.
26. Take necessary action during emergency situation and disaster period.
27. Take precautions regarding epidemic and take initiatives to protect it.
28. Fill in MIS form and send it to UH&FWC for further action.
29. Prepare an inventory of goods of CC, and ensure proper care of documents with cleanliness.
30. Identify needs of medicines and necessary goods, collect these, and send indent to UH&FWC.
31. Dispose of clinical wastes (specially disposable syringe and needle).
32. Provide other services from CC and SC.

Referrals

Refer complicated patients of health and family planning to UH&FWC/UHC after giving preliminary treatment by HA/FWA e.g.

1. Identify and refer severely malnourished babies to higher authority.
2. Refer diarrhoea, ARI, malaria, TB, leprosy, measles, kala-azar, and communicable diseases to the higher authority at emergency situation.
3. Refer severe injured, snakebite, dog bite, drowned in water, fire burn, acid burn, and high fever patients to higher authority after giving primary treatment.
4. Refer high-risk pregnant women and delivery patients to higher authority.
5. Refer MR patients and patients with post-abortion complications to higher level.

6. Refer patients willing to take permanent/long-term measure for family planning to the proper centre.
7. Refer patients to higher level for management of side-effects.

Domicilliary level

1. Distribute required drugs for filariasis patients once a year.
2. Distribute antehelmenthic drugs to persons with symptoms.
3. Remain vigilant about acute flaccid paralysis (AFP), measles, neonatal cases, and other communicable diseases, and inform all about their prevention and control.
4. Identify drop-outs of family-planning methods, and ensure acceptance.
5. Trace patients under treatment against TB, leprosy, and severe malaria not coming to clinics, and bring them under treatment.
6. Contact and motivate pregnant women individually to visit clinics for antenatal care, including immunization.
7. Conduct home delivery (safe and hygienic)
8. Visit households of the disabled, unwilling persons and people living in distant area, and provide services.
9. Observe carefulness about the incidence of communicable diseases, and participate in the prevention.
10. Perform any other jobs assigned.

Source:*Specific job description of officials and staff working at upazila level and below. Dhaka: Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh. 1999: 129-130*

Appendix 2

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য অধিদপ্তর
মহাখালী, ঢাকা ১২১২।

স্মারক নং-স্বাঃঅধি/এমএন্ডপিডিসি/৯/জিআর/৯৬-৯৭/ওপিএন/২০০০/২৮৪(৫২৪) তারিখঃ ১৭/১/২০০০

বরাবর,
১. সিভিল সার্জন (সকল)
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২. থানা স্বাস্থ্য ও পরিবার পরিকল্পনা কর্মকর্তা (সকল)।
থানাঃ---------- জেলাঃ----------

বিষয়ঃ ২০০০ সনে অনুষ্ঠিতব্য ভৌগলিক পর্যবেক্ষণ শুদ্ধিকরন এর কাজ প্রসংগে।

নতুন শতাব্দীর শুভলগ্নে আন্তরিক শুভেচ্ছা জানাচ্ছি। সরকার স্বাস্থ্য ও পরিবার পরিকল্পনা সেক্টরে যুগান্তকারী সংস্কারের মাধ্যমে HPSP কার্যক্রম চালু করেছে। ইতিমধ্যেই জারীকৃত এসআরও এর ক্ষমতা বলে সরকার গত ৩১/৮/৯৯ তারিখে প্রশাসন-১/১ই-০৫/৯৯/৬৯২ নং আদেশ দ্বারা থানা ও তদনিম্ন পর্যায়ে বিদ্যমান মঞ্জুরীকৃত জনবলের সমন্বয়ে একীভূত কাঠামো স্বাস্থ্য ও পরিবার পরিকল্পনা গঠন করেছে। একীভূত কাঠামোর আওতায় মাঠ পর্যায়ে ব্যবহারের জন্য UMIS কর্তৃক বিভিন্ন রকম নতুন ফরম প্রস্তুত করে জেলা ও থানা পর্যায়ে প্রেরণ করা হয়েছে। জিআর আপডেটিং কাজের আনুষঙ্গিক ব্যয় নির্বাহের জন্য UMIS এবং অত্র দপ্তর হতে যথাক্রমে থানা স্বাস্থ্য ও পঃ পঃ কর্মকর্তা এবং সিভিল সার্জন এর বরাবরে পৃথক পৃথক ভাবে অর্থ বরাদ্দ করা হয়েছে। বর্তমান প্রেক্ষাপটে এ বৎসরের ভৌগলিক পর্যবেক্ষণ শুদ্ধিকরণের কাজ বিশেষ তাৎপর্যপূর্ণ। যথাযথ ভাবে ভৌগলিক পর্যবেক্ষণ শুদ্ধিকরণ কাজ সম্পাদনের গুরুত্ব অনস্বিকার্য। সুষ্ঠু ভাবে উক্ত কাজ সম্পাদনের লক্ষে নিম্নোক্ত বিষয় গুলির প্রতি আপনার মনোযোগ আকর্ষণ করছি।

১। অত্র দপ্তর হতে প্রেরিত স্মারক নং স্বাঃঅধি/এমএন্ডপিডিসি/জিআর/৯/জিআর/৯৬-৯৯/ওপিএন/১৪৫১৯(৬৪) তারিখঃ ২৮/১১/৯৪ইং এর মাধ্যমে প্রেরিত পূর্বের ফরমের নমুনার পরিবর্তে UMIS কর্তৃক প্রেরিত নতুন 'ফরম' ভৌগলিক পর্যবেক্ষণ শুদ্ধিকরণ কাজ সম্পাদন করতে হবে।

২। যেহেতু বর্তমান জি আর এর পূর্বে পূর্নাংঙ্গ প্রশিক্ষণ দেওয়া সম্ভব নয়। বিধায় স্থানীয় ভাবে জেলা এবং থানা পর্যায়ে সংশ্লিষ্ট কর্মকর্তা/কর্মচারীদেরকে ডেকে 'ফরম' পূরণ সংক্রান্ত অবহিত করন আলোচনা করে জি আর শুদ্ধিকরন কাজ করতে হবে এবং আগামী মে'২০০০ সনের মধ্যে প্রতিবেদন প্রেরণ করতে হবে।

৩। UMIS এবং অত্র দপ্তর হতে পৃথক পৃথক ভাবে প্রদত্ত অর্থ বরাদ্দ স্থানীয়ভাবে সমন্বয় ব্যবস্থাপনার মাধ্যমে জি আর এর ব্যয় নির্বাহ করতে হবে। UMIS কর্তৃক ন্যাস্তকৃত অর্থের দ্বারা প্রয়োজনীয় সরঞ্জামাদি ক্রয় করতে হবে এবং অত্র দপ্তর হতে ন্যাস্তকৃত অর্থ দ্বারা UMIS কর্তৃক সরবরাহকৃত 'ফরম' সংকুলান না হলে স্থানীয়ভাবে উক্ত ফরম মুদ্রন করে জি আর শুদ্ধি করণের কাজ সমাধা করতে হবে।

৪। জি আর শুদ্ধিকরন করার সময়ে প্রতিটি ঘরে অবশ্যই আলকাতরা দিয়ে নম্বর দিতে হবে। খেয়াল রাখতে হবে যেন একটি বাড়ীও নম্বর ছাড়া না থাকে। নুতন বাড়ী হলে বাটা নম্বর অবশ্যই দিতে হবে। গ্রামের প্রথম বাড়ীর পার্শ্বে কোন নির্দিষ্ট মৌজা নং ও নাম, ওয়ার্ড নং- ইউনিয়ন নং ও নাম ও ব্লক নম্বর থাকতে হবে। এক বাড়ী হতে অন্য বাড়ী হতে অন্য বাড়ীতে যাওয়া এরো ও প্রসেভিং চিহ্ন দিতে হবে। গ্রামের প্রথম ও শেষ বাড়ীতে আরম্ভ ও শেষ চিহ্ন যথাক্রমে বাড়ীতে পরিষ্কার করে লিখতে হবে। প্রতি পঞ্চাশ বাড়ী অন্তর অন্তর জে- এল নং ও নাম,

ব্লক নং দিতে হবে। বাড়ীতে নম্বরও দেওয়ার সাথে সাথে মৌজা মানচিত্র তৈরী/আপডেট করতে হবে। ইহাতে কোন অবহেলা চলবে না।

৫। স্বাস্থ্য ও পরিবার পরিকল্পনা বিভাগের মাঠ কর্মীদের সমন্বয়ে একটি স্কোয়াড (অর্থাৎ একজন HA ও একজন FWA) দল গঠন করে জি আর শুদ্ধিকরন কাজ করতে হবে।

৬। নুতর ফরমে (UMIS কর্তৃক সরবরাহকৃত) জনসাধারণের ব্যবহার্য্য বাড়ী/প্রতিষ্ঠান (P.U.) এর কোন কলাম না থাকায় ফরমের ডানপার্শ্বে PU এর বাড়ী নং দেয়া যেতে পারে। উল্লেখ্য ফরমে উল্লিখিত 'খানা নং' কে বসতবাড়ী গন্য করতে হবে।

৭। জেলা/থানা পর্যায়ে সংশ্লিষ্ট কর্মকর্তার সমন্বয়ে পৃথক পৃথক টিম গঠন করে সার্বক্ষনিক জি আর আপডেটিং কার্যক্রম তদারকীর ব্যবস্থা গ্রহন করতে হবে।

স্বাক্ষর- (অস্পষ্ট)
(ডঃ এ, এম, জাকির হোসেন)
পরিচালক
প্রাথমিক স্বাস্থ্য পরিচর্যা ও রোগ নিয়ন্ত্রন
এবং
লাইন ডাইরেক্টর, ইএসপি
স্বাস্থ্য অধিদপ্তর, মহাখালী
ঢাকা-১২১২

স্মারক নং-স্বাঃঅধি/এমএন্ডপিডিসি/৯/জি আর/৯৬-৯৭/ও পি এন/২০০০

তারিখঃ-

অনুলিপি সদয় অবগতি ও প্রয়োজনীয় ব্যবস্থা গ্রহণার্থে প্রেরণ করা হলোঃ-

১। মহা-পরিচালক, স্বাস্থ্য অধিদপ্তর, মহাখালী, ঢাকা-১২১২।
(দৃঃআঃ সহকারী পরিচালন, সমন্বয়, স্বাস্থ্য অধিদপ্তর।
২। লাইন ডাইরেক্টর, ইউ আই এস, স্বাস্থ্য অধিদপ্তর।
৩। লাইন ডাইরেক্টর, ইএসপি, পরিবার পরিকল্পনা অধিদপ্তর।
৪। পরিচালক (স্বাস্থ্য), ঢাকা/চট্টগ্রাম/রাজশাহী/খুলনা/বরিশাল।

স্বাক্ষর- (অস্পষ্ট)
(ডঃ এ, এম, জাকির হোসেন)
পরিচালক
প্রাথমিক স্বাস্থ্য পরিচর্যা ও রোগ নিয়ন্ত্রন
এবং
লাইন ডাইরেক্টর, ইএসপি
স্বাস্থ্য অধিদপ্তর, মহাখালী
ঢাকা-১২১২

Geographical Reconnaissance (GR) Register

Name of worker: .....

Community Clinic: .....

Ward no. ……..……..... Union: .....

Thana: ……..…..... District: .....

Month: ……..... Year: .....

UMIS/GR/Register-1/Section-1
To be filled up by Health Assistant and Family Welfare Assistant

Mouza no..... Mouza name: ..... Ward no. ..... Union: ..... Thana: ..... District: .....

Sl. no.	Household no.	Name of the household head	Population															No. of currently pregnant woman	No. of live-births during last year (by place of delivery)				Breast-feeding status				Source of drinking water[1]	Type of latrine used[2]
			Age distribution*												Total				At hospital /clinic		At home		Colostrum given		Exclusively breastfed			
			0-11 months(s)		11-23 month(s)		2-4 years		5-14 years		15-49 years		50+ years															
			M	F	M	F	M	F	M	F	M	F	M	F	M	F	T		M	F	M	F	M	F	M	F		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
Total																											S=	W=
																											T=	P=
																											O=	O=

* Age distribution: **0-11 month(s)** = 11 months 29 days after LB; **12-23 month** = From 12 to 23 months and 29 days; **2-4 years** = From 2 to 4 years 11 months and 29 days; **5-14 years** = 5 to 14 years 11 months and 29 days **15-49 years** = From 15 to 49 years 11 months and 29 days; **50+ years** = 50 years and above.

1. Source of drinking water: **S** = Supply **T** = Tubewell **O** = Other

2. Type of latrine used: **W** = Water seal **P** = Pit **O** = Others

Sl. no.	HH no.	Total ELCO	Family planning-related										Child immunization				No. of children <5 years of age received 2-dose VAC during last year		Women TT		Death during last year								
			Family planning method user							Source of methods			12-23 months old children								0-28 day(s)		29 days – 11 months		1-4 year(s)		5 years and above		Maternal*
			Oral pill	Condom	Injectables	IUD	Norplant	Male sterilization	Female sterilization	GoB	NGO	Market	DPT3		Measles/ OPV-4				TT 2-4 doses given	TT5 doses given									
													M	F	M	F	M	F			M	F	M	F	M	F	M	F	
30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59
Total																													

* **Maternal** = Death during pregnant, delivery, or 42 days after delivery

Yearly Morbidity Tally Sheet

(To be filled up by Health Assistant and Family Welfare Assistant)

Community Clinic: …….. Ward no. ……. Union: …….. Thana: …….. District: ……..

Total number of households visited	Name of diseases	Number of cases					Source of treatment			
		Male		Female		Total	Govt. hospital or clinic		Non-govt./private hospital or clinic	
Tally		Tally	Total	Tally	Total		Tally	Total	Tally	Total
	1. Diarrhoea									
	2. Dysentery									
	3. Pneumonia									
	4. Tuberculosis									
	5. Polio									
	6. Leprosy									
	7. Malnutrition									
	8. Anaemia									
	9. Goitre									
	10. Tetanus									
	11. Malaria									
	12. Filariasis									
	13. Nightblindness									
	14. Measles									
Total										

Appendix 4

Appendix 4

গণপ্রজাতন্ত্রী বাংলাদেশ সরকার
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
সিনিয়র সহকারী প্রধান-২

স্বাপকম/পক (পরি)/সি.সপ্র -২/২৫/৮৯ তারিখঃ ২৪/৩/৯৯

প্রজ্ঞাপন

স্বাস্থ্য ও জনসংখ্যা সেক্টর কর্মসূচী (HPSP) এর Unified Management Information System (UMIS) বাস্তবায়ন এবং পর্যায়ক্রমে কর্মসূচীর পর্যালোচনার নিমিত্তে নিম্নে বর্ণিত UMIS Implementation Task Force গঠন করা গেল।

কমিটির গঠনঃ

১.	ডাঃ এ. এম. জাকির হোসেন, স্বাস্থ্য অধিদপ্তর	আহ্বায়ক
২.	ডাঃ নুরুল আনোয়ার, লাইন ডাইরেক্টর, ইউএমআইএস, স্বাস্থ্য অধিদপ্তর	সদস্য
৩.	ডাঃ শামসুল হক, লাইন ডাইরেক্টর, ইএসপি (প্রজনন স্বাস্থ্য ব্যতীত), স্বাস্থ্য অধিদপ্তর	সদস্য
৪.	ডাঃ জহির উদ্দিন আহমেদ, লাইন ডাইরেক্টর, (প্রজনন স্বাস্থ্য), পরিবার পরিকল্পনা অধিদপ্তর	সদস্য
৫.	মিঃ রফিকুল ইসলাম, টিও, এমসিইউ	সদস্য
৬.	ডাঃ এস. এম. আসিব নাসিম, পিসিসি	সদস্য
৭.	ডঃ তোফায়েল আহমেদ, পিএম, ইউএমআইএস, পরিবার পরিকল্পনা অধিদপ্তর	সদস্য
৮.	জনাবা, দিলরুবা ইয়াসমিন, সিনিয়র সহকারী প্রধান, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়	সদস্য
৯.	ডঃ ক্রিস টুনন, ম্যানেজমেন্ট সাইনটিষ্ট, ওআরপি, আইসিডিডিআরবি	সদস্য
১০.	ডাঃ তারিক আজিম, সিনিয়র অপারেশনস্ রিসার্চার, ওআরপি, আইসিডিডিআর,বি	সদস্য

কমিটির Terms of Reference (TOR):

ক. Operational Plan এর আলোকে বাজেট সহ work plan প্রস্তুত করা।
খ. এক মাসব্যাপী ওআরপি, আইসিডিডিআরবি-এর তিনটি এলাকায় ফিল্ড টেস্ট মনিটর করা।
গ. ফিল্ড টেষ্ট শেষে ফলাফল জাতীয় কর্মশালার মাধ্যমে পর্যালোচনা করে UMIS কর্মসূচী চূড়ান্ত করা।
ঘ. সারা দেশে UMIS ফরমেটসমূহ চালু করার পর ওআরপি, আইসিডিডিআর,বি-এর তিনটি নির্বাচিত এলাকা সহ সাতটি জেলায় (মানিকগঞ্জ, রাজশাহী, পিরোজপুর, কুমিল্লা, যশোর, বাগেরহাট এবং চট্টগ্রাম) UMIS কর্মসূচী ছয় মাসব্যাপী ইন্‌টেন্সিভ মনিটর করা।
ঙ. ফরমসমূহ সারাদেশব্যাপী প্রচলনের ছয় মাস পর মনিটরিং এর মাধ্যমে প্রাপ্ত ফলাফলের ভিত্তিতে একটি জাতীয় কর্মশালায় UMIS কর্মসূচী মূল্যায়ন করা।
চ. প্রযোজ্য ক্ষেত্রে ফরমসমূহ প্রয়োজনীয় সংস্কার সাধনপূর্বক মন্ত্রণালয়ের অনুমোদন সাপেক্ষে সারা দেশে চালু করা।

স্বাক্ষরঃ- অস্পষ্ট
(দিলরুবা ইয়াসমিন)
সিনিয়র সহকারী প্রধান
ফোনঃ ৮৬৫১৮২

বিতরনঃ

১. ডাঃ এ. এম. জাকির হোসেন, স্বাস্থ্য অধিদপ্তর
২. ডাঃ নুরুল আনোয়ার, লাইন ডাইরেক্টর, ইউএমআইএস, স্বাস্থ্য অধিদপ্তর
৩. ডাঃ শামসুল হক, লাইন ডাইরেক্টর, ইএসপি (প্রজনন স্বাস্থ্য ব্যতীত), স্বাস্থ্য অধিদপ্তর
৪. ডাঃ জহির উদ্দিন আহ্‌মেদ, লাইন ডাইরেক্টর, (প্রজনন স্বাস্থ্য), পরিবার পরিকল্পনা অধিদপ্তর
৫. মিঃ রফিকুল ইসলাম, টিও, এমসিইউ
৬. ডাঃ এস. এম. আসিব নাসিম, পিসিসি
৭. ডঃ তোফায়েল আহ্‌মেদ, পিএম, ইউএমআইএস, পরিবার পরিকল্পনা অধিদপ্তর
৮. ডঃ ক্রিস টুনন, ম্যানেজমেন্ট সাইনটিষ্ট, ওআরপি, আইসিডিডিআরবি
৯. ডাঃ তারিক আজিম, সিনিয়র অপারেশনস্ রিসার্চার, ওআরপি, আইসিডিডিআর,বি

স্বাপকম/পক (পরি)/সি.সপ্র -২/২৫/৮৯ তারিখঃ ২৩/৩/৯৯

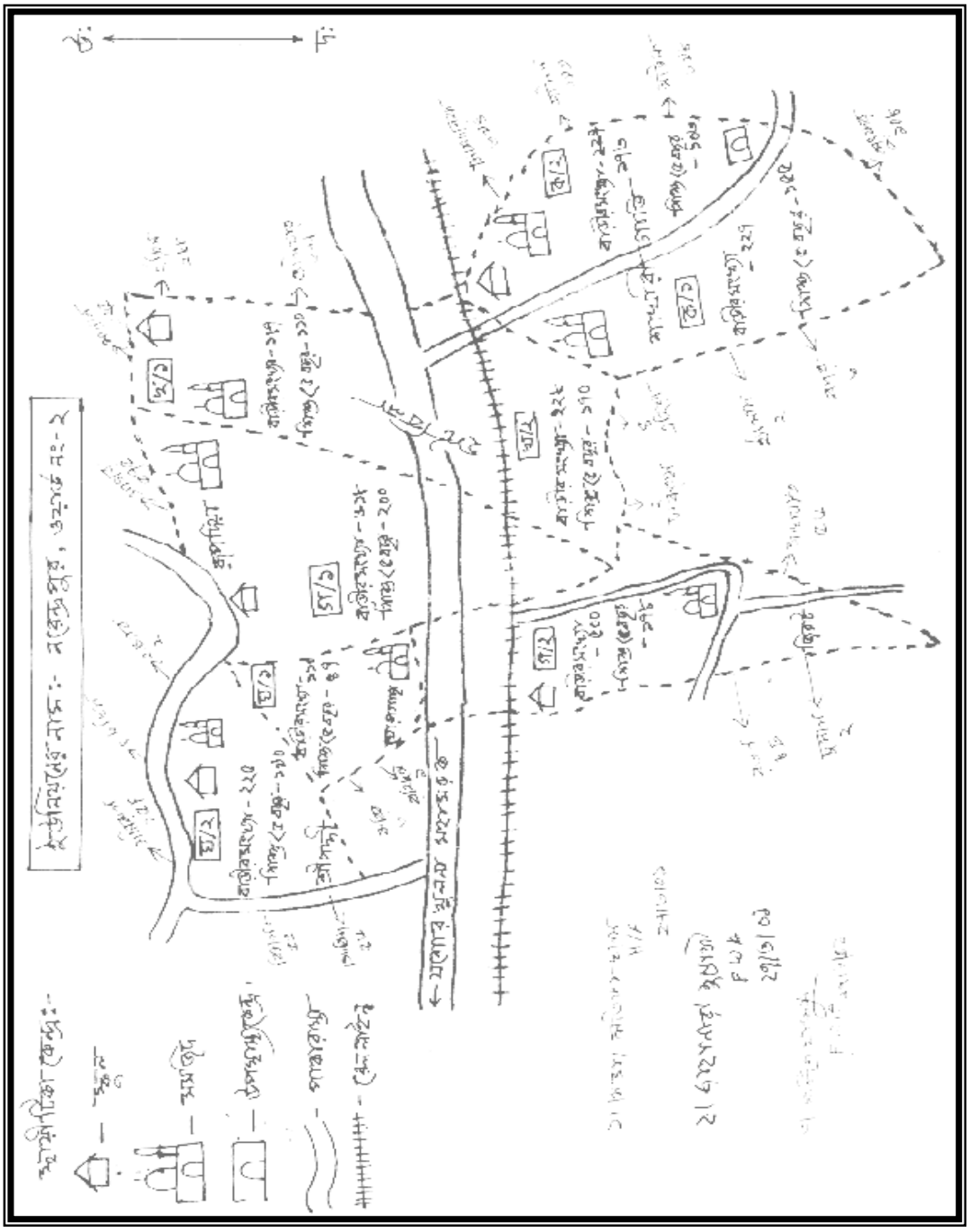
সদয় জ্ঞাতার্থে অনুলিপি প্রদান করা হলোঃ

১. সচিব মহোদয়ের একান্ত সচিব, স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়, ঢাকা।
২. যুগ্ম প্রধান মহোদয়ের ব্যক্তিগত কর্মকর্তা, স্বাস্থ্য ও পরিবার কল্যণ মন্ত্রণালয়, ঢাকা।
৩. উপ-প্রধান (স্বাস্থ্য) এর ব্যক্তিগত কর্মকর্তা, স্বাস্থ্য ও পরিবার কল্যণ মন্ত্রণালয়।

স্বাক্ষরঃ- অস্পষ্ট
(দিলরুবা ইয়াসমিন)
সিনিয়র সহকারী প্রধান
ফোনঃ ৮৬৫১৮২

Appendix 5

Sample Mouza Map of a Ward



Appendix 6

List of Indicators of Geographical Reconnaissance

1. **Total number of households**
2. **Name of the household head**
3. **Population by age and sex:**
   0-11 month(s), 11-23 months, 2-4 years, 5-14 years, 15-49 years, 50+ years, and total number of population
4. **Number of women currently pregnant**
5. **Number of live-births by sex during last one year**
   Institutional and home
6. **Breast-feeding status by sex of children**
   Colostrums given, exclusively breastfed
7. **Source of drinking water**
   Supply, tubewell and others
8. **Type of latrine used**
   Water seal, pit, and others
9. **Total number of eligible couples or ELCOs**
10. **Family-planning users**
    Oral pill, condom, injectables, IUD, norplant, male sterilization, and female sterilization
11. **Source of method**
    GoB and others
12. **Child (12-23 months by sex) immunization**
    DPT3, measles and OPV4.
13. **Number of children aged less than 5 years and sex received 2-dose vitamin A during last year**
14. **Women received TT**
    2-4 doses and 5 doses.
15. **Births**
16. **Death by sex during last year**
    0-28 day(s), 29 days -11 months, 1-4 year(s), 5 years and above, and maternal deaths

[Source: GR Register]

Mouzawise Geographical Reconnaissance (GR) Report of Ward/Community Clinic

(To be compiled by Health Assistant and Family Welfare Assistant)

Community Clinic: ..... Union: ..... Thana: ..... District: ..... Month: ..... Year: .....

Sl. no.	Mouza name	Population															No. of currently pregnant woman	No. of live-births during last year (by place of delivery)				Breast-feeding status				Source of drinking water[1]			Type of latrine used[2]		
		Age distribution*												Total				At hospital /clinic		At home		Colostrum given		Exclusively breastfed							
		0-11 months(s)		11-23 month(s)		2-4 years		5-14 years		15-49 years		50+ years																			
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	T		M	F	M	F	M	F	M	F	Supply	Tube-well	Others	Water seal	Pit	Others
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Total																															

* Age distribution: **0-11 month(s)** = 11 months 29 days after LB; **12-23 month** = From 12 to 23 months and 29 days; **2-4 years** = From 2 to 4 years 11 months and 29 days; **5-14 years** = 5 to 14 years 11 months and 29 days **15-49 years** = From 15 to 49 years 11 months and 29 days; **50+ years** = 50 years and above.

1. Source of drinking water: **S** = Supply **T** = Tubewell **O** = Other

2. Type of latrine used: **W** = Water seal **P** = Pit **O** = Others

Sl. no.	Mouza name	Total number of eligible couples	Family planning-related													Child immunization				No. of children <5 years of age received 2-dose VAC during last year		Women TT		Death during last year								
			Family planning method user									Source of methods				12-23 months old children								0-28 day(s)		29 days – 11 months		1-4 year(s)		5 years and above		
			Oral pill	Condom	Injectables	IUD	Norplant	Male sterilization	Female sterilization	Total	CPR	GoB	NGO	Market		DPT3		Measles/ OPV-4				TT 2-4 doses given	TT5 doses given									Maternal*
																M	F	M	F	M	F			M	F	M	F	M	F	M	F	
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47		48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64
Total																																

* **Maternal** = Death during pregnant, delivery, or 42 days after delivery

Signature
Family Welfare Assistant

Signature
Health Assistant

Yearly Morbidity Report of Ward/Community Clinic

(To be compiled by Health Assistant and Family Welfare Assistant)

Month: ……..……. Year: ……....

Ward no. ..... Community Clinic: ……..…. Union: ……..……. Thana: ……..……. District: ……..……

Total number of households visited	Name of diseases	Number of cases		Source of treatment	
		Male	Female	Govt. hospital or clinic	Non-govt./private hospital or clinic
	1. Diarrhoea				
	2. Dysentery				
	3. Pneumonia				
	4. Tuberculosis				
	5. Polio				
	6. Leprosy				
	7. Malnutrition				
	8. Anaemia				
	9. Goitre				
	10. Tetanus				
	11. Malaria				
	12. Filariasis				
	13. Nightblindness				
	14. Measles				
Total:					

.....
Signature
Family Welfare Assistant
Date: ..... /..... /.....

.....
Signature
Health Assistant
Date: ..... /..... /.....

Ward/Community Clinicwise Geographical Reconnaissance (GR) Report of Union

(To be compiled by Assistant Health Inspector and Family Planning Inspector)

Union: ……..... Thana: …… District: …… Month: ..... Year: .....

Sl. no.	Name of Ward/ Community Clinic	Population														No. of currently pregnant woman	No. of live-births during last year (by place of delivery)				Breast-feeding status				Source of drinking water[1]			Type of latrine used[2]		
		Age distribution*												Total			At hospital /clinic		At home		Colostrum given		Exclusively breastfed		Supply	Tube-well	Others	Water seal	Pit	Others
		0-11 months(s)		11-23 month(s)		2-4 years		5-14 years		15-49 years		50+ years																			
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	T	M	F	M	F	M	F	M	F						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Total																															

* Age distribution: **0-11 month(s)** = 11 months 29 days after LB; **12-23 month** = From 12 to 23 months and 29 days; **2-4 years** = From 2 to 4 years 11 months and 29 days; **5-14 years** = 5 to 14 years 11 months and 29 days **15-49 years** = From 15 to 49 years 11 months and 29 days; **50+ years** = 50 years and above.

1. Source of drinking water: **S** = Supply **T** = Tubewell **O** = Other

2. Type of latrine used: **W** = Water seal **P** = Pit **O** = Others

Sl. no.	Name of Ward/ Community Clinic	Total number of eligible couples	Family planning-related													Child immunization				No. of children <5 years of age received 2-dose VAC during last year		Women TT		Death during last year								
			Family planning method user										Source of methods			12-23 months old children								0-28 day(s)		29 days – 11 months		1-4 year(s)		5 years and above		
			Oral pill	Condom	Injectables	IUD	Norplant	Mal e sterilization	Female sterilization	Total	CPR	GoB	NGO	Market	DPT3		Measles/ OPV-4				TT 2-4 doses given	TT5 doses given									Maternal*
															M	F	M	F	M	F			M	F	M	F	M	F	M	F	
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64
Total																															

* **Maternal** = Death during pregnant, delivery, or 42 days after delivery

.....
Signature
Family Welfare Assistant

.....
Signature
Health Assistant

Yearly Morbidity Report of Union

(To be compiled by Assistant Health Inspector and Family Planning Inspector)

Month: …….. Year: ……

Union: …….. Thana: …….. District: ……

Total number of households visited	Name of diseases	Number of cases		Source of treatment	
		Male	Female	Govt. hospital or clinic	Non-govt./private hospital or clinic
	1. Diarrhoea				
	2. Dysentery				
	3. Pneumonia				
	4. Tuberculosis				
	5. Polio				
	6. Leprosy				
	7. Malnutrition				
	8. Anaemia				
	9. Goitre				
	10. Tetanus				
	11. Malaria				
	12. Filariasis				
	13. Nightblindness				
	14. Measles				
Total:					

.....
Signature
Family Welfare Assistant
Date: ..... /..... /.....

.....
Signature
Health Assistant
Date: ..... /..... /.....

Union wise Geographical Reconnaissance (GR) Report of Thana

(To be compiled by Health Inspector)

Thana: …… District: …… Month: ..... Year: .....

Sl. no.	Name of union	Population														No. of currently pregnant woman	No. of live-births during last year (by place of delivery)				Breast-feeding status				Source of drinking water[1]			Type of latrine used[2]		
		Age distribution*												Total			At hospital /clinic		At home		Colostrum given		Exclusively breastfed		Supply	Tube-well	Others	Water seal	Pit	Others
		0-11 months(s)		11-23 month(s)		2-4 years		5-14 years		15-49 years		50+ years																			
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	T	M	F	M	F	M	F	M	F						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
Total																															

* Age distribution: **0-11 month(s)** = 11 months 29 days after LB; **12-23 month** = From 12 to 23 months and 29 days; **2-4 years** = From 2 to 4 years 11 months and 29 days; **5-14 years** = 5 to 14 years 11 months and 29 days **15-49 years** = From 15 to 49 years 11 months and 29 days; **50+ years** = 50 years and above.

1. Source of drinking water: **S** = Supply **T** = Tubewell **O** = Other

2. Type of latrine used: **W** = Water seal **P** = Pit **O** = Others

Sl. no.	Name of union	Total number of eligible couples	Family planning-related													Child immunization				No. of children <5 years of age received 2-dose VAC during last year		Women TT		Death during last year								
			Family planning method user										Source of methods			12-23 months old children								0-28 day(s)		29 days – 11 months		1-4 year(s)		5 years and above		
			Oral pill	Condom	Injectables	IUD	Norplant	Male sterilization	Female sterilization	Total	CPR	GoB	NGO	Market	DPT3		Measles/ OPV-4				TT 2-4 doses given	TT5 doses given									Maternal*
															M	F	M	F	M	F			M	F	M	F	M	F	M	F	
33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64
Total																															

* **Maternal** = Death during pregnant, delivery, or 42 days after delivery

.....
Signature
Health Inspector

Yearly Morbidity Report of Thana

(To be compiled by Health Inspector)

Month: …… Year: …… Thana: …… District: ……

Total number of households visited	Name of diseases	Number of cases		Source of treatment	
		Male	Female	Govt. hospital or clinic	Non-govt./private hospital or clinic
	15. Diarrhoea				
	16. Dysentery				
	17. Pneumonia				
	18. Tuberculosis				
	19. Polio				
	20. Leprosy				
	21. Malnutrition				
	22. Anaemia				
	23. Goitre				
	24. Tetanus				
	25. Malaria				
	26. Filariasis				
	27. Nightblindness				
	28. Measles				
Total:					

.....

Signature
Health Inspector
Date: ..... /..... /.....