

AN ASSESSMENT OF HEALTH AND NUTRITION OF WOMEN IN THE RMP NUTRITION PILOT



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EXECUTIVE SUMMARY

The RMP-Nutrition Pilot is a innovative project of CARE-Canada. In September 2003, a two-person Health and Nutrition Capacity Assessment Team of CARE-Canada recommended this pilot to improve the nutritional status of RMP crew and their household members. Keeping in mind the overall objective to observe the changes in nutritional status of RMA women, the Nutrition Pilot Project was started in July 1, 2004. As part of this Nutrition Pilot Project a group of 10 women in each Union Parishad participated in the program and during project cycle these women receive different trainings to develop their human resource. RMP has conducted special training for the RMA women in Nutrition Pilot areas (2 Upazillas in Jessore and Mymensingh area) and has linked them with the service providers providing health care services in the area.

The objectives to assess the Nutrition Pilot were as follows:

1. Assess health and nutrition practices of the women in Nutrition Pilot area; and
2. Assess to what extent the linkage services received by the women are functional.

In case of Nutrition Pilot as in the pilot design itself, a case control method was followed and the respondents were divided into three groups namely case (Intervention), Comparison and Control groups. Here we took 30 women from each Intervention and Control groups and 30 from Comparison groups proportionately chosen from Mymensingh and Jessore. Thus, on the whole 90 interviews, 2 FGDs, and 3 KIIs were administered during the evaluation study.

In congruence with the stipulations of the *Terms of Reference*, a seven-member multidisciplinary core study team was proposed. The core-team was guided by Lead Researcher, Prof. Abul Barkat, a development economist by education. All other members of the core team are well reputed in their respective areas of specialization in which two were medical doctors.

Characteristics of Respondents

Overall distributional pattern of respondents by age shows minor skewed curve. Majority of the respondents (66%) were in the age group of 21-32 years and modal age group was 27-32 years (38%). Among intervention group such skewness was more (63%). In control group over 73 percent belonged to this group. However, in Comparison group, age distribution was more or less symmetrical having 20 percent below 27 years and 7 percent above 38 years. Average age of respondents was 30 years. However, high degree of marital disorder (divorce, widow, separation, abandonment, etc.) prevails in these women in spite of their young age. Among Intervention women, only 13 percent were currently married and it was only 10 percent among Control groups.

Among Control group, family size was bigger compared to two other groups. Modal family size was 4 members family. Over 91 percent respondents were household heads themselves. In both Intervention and Control groups it was even more – 93 percent in each group and in Comparison group it was 88 percent were household heads.

Respondent profile in terms of education attainment was not encouraging. Among Intervention women 90% have no education at all or can sign only. In other groups also illiteracy was very high, 87% among Comparison and 70 percent among Control groups.

Among Control group there was more diversity of occupation compared to other two groups. Among Intervention women, agri-laboring, non-agri-laboring, business, poultry rearing were totally absent.

With respect to vulnerable group, Intervention group was relatively better. More than 96 percent of this group belongs to low-vulnerable group while 91 percent of Comparison group and 87 percent of Control group do so. In Control groups over 13% belonged to high-vulnerable group, which was 9 percent in Comparison group and 3 percent in Intervention group.

All the FGD participants were working under RMP project, i.e. RMA women. There were three participants in KII of which two were UP members and one was CARE field personnel.

Findings

The issue of awareness of crucial public health issue appeared as a proxy of anthropometry. Ninety percent RMA women in Intervention group have a clear idea about the number of diseases against which immunization (EPI) is given to the children. However, one-fourth and one-third of the respondents from Comparison and Control groups respectively could not mention the correct number of diseases against which immunization is given. As regards their knowledge about the relationship between iodized salt and goitre, majority (87%) of the respondents of the Intervention group, half of the respondents from Comparison and less than half (43%) in Control groups were found aware of it. Although majority (85%) of the respondents from Intervention group reported knowing about the cause of night blindness, it was known only to half of the respondents from Comparison and one-third (37%) in Control groups. Regarding the concept about sanitary latrine, substantially there was no such difference in knowledge gap between the respondents of Intervention (87%) and Comparison (87%) group. However, there was a substantial difference with Control group (63%).

Based on the survey findings, higher state of knowledge is evident among the respondents of Intervention group compared to those in Comparison and Control group. The Intervention group has the least knowledge gap and those in the Control group depicted the highest knowledge gap.

It is worthwhile to mention here that the *training on nutrition education* imparted to the RMA women by the workers of RMP-Nutrition Pilot of CARE played a considerable role to raise the knowledge of the respondents on public health in Intervention group. While, national health programme of the country can be considered as a crucial source of knowledge among the Comparison and Control groups.

Most of the illness were associated with 'fever' (43-48%), distantly followed by stomach pain, jaundice and diarrhoea/dysentery. People face much problem in receiving treatment from proper people, as trained in the Nutrition Pilot. It has been found in the survey that only 19 percent of people from Intervention area and far below (5%) from Comparison and Control went to govt. hospital/THC for treatment. They were not utilizing GOB facility, and visiting spiritual healer, local pharmacy or village doctor. They didn't go to these doctor/paramedic because the MBBS doctors and paramedics prescribe medicine costly for them.

Special care for children was an important issue in the training of Nutrition pilot. HDRC team had in-depth analysis of this, regarding how they take care of the children under 1 to 5 years, types of food they provide to them, and things to be done if they become thin and weak.

It has been reported by around 45 percent of the mothers in the Intervention areas about provisioning of all types of care to their children 1-5 years. All these were done in comparatively much lower proportion in Comparison and Control areas.

The reporting shows that the mothers of Comparison and Control areas are more likely to provide cereals to their children below 6 months. Whereas, in Intervention areas the mothers are more likely to provide milk and milk products. The RMA women during FGD informed that after birth, they still give hot water and/or honey before breastmilk. Breastmilk-only is a rare practice for the newborn.

Regarding the things to be done if the child becomes thin and weak they had almost the same suggestions in all the areas.

Practice of handwashing before meal and after defecation are with the range of 77 percent in the Control areas, it was 93 percent for Comparison and 97 percent in Intervention areas. During FGD, the RMA women informed that most of them wash hand with water from tube well before meals, some of them use soaps. Others wash hand with ash or mud after defecation. They use sand for going to latrine. They also use hygienic latrine. They have learned it from Nutrition Pilot training of CARE.

Regarding immunization status of women 33 percent of the RMA women in Intervention areas reported that they are fully immunized. It was only 13 percent in Control area and 3 percent in Comparison area. Almost two-thirds in all the areas reported that they are partly immunized. Their source of information was verbal in most of the cases (in all the areas).

The immunization status of children were asked, and they were requested to show the immunization card in support of this. In Intervention areas 50 percent of the boys and 33 percent of the girls were fully immunized, as RMA women reported. In Comparison and Control areas it was far lower for boys (25% each). However, for girls, only 11 percent in Comparison and 44 percent in Control areas reported of 'full immunization'. During FGD the RMA women supported EPI for 6 dangerous diseases.

Regarding information source about immunization they were able to show EPI cards in 75 percent for boys and 76 percent for girls in Intervention areas. Whereas, in Comparison and Control areas it was 50 percent each for boys and none in case of girls. All these activities indicate their negligence towards girls.

With regard to knowledge about the benefit of iodized salt over non-iodized salt, there is distinct gap between the Intervention and non-intervention groups.

During key informant interview (KII) the local leaders and CARE peoples were of opinion that there is a great change regarding knowledge and practice of the women. Now, they have become more aware of their health. They can decide what to do. Now, they take balanced diet. Other peoples are following them.

Cent percent of the RMA women in the Intervention, Comparison and Control areas reported that their children has been given Vitamin A Capsule (VAC) during the last 6 months. Status of children suffering from measles (anytime) and provisioning of VAC after suffering from measles was also high. During FGD the RMA women reported that they have learned it from the source of RMP-Nutrition Pilot-CARE.

During Key Informant Interview (KII) the UP members were of opinion that some women had more success since they are implementing their acquired knowledge from the source of CARE. Some women are near to bazar, hospital and union parishad. So, they could easily expand their business. Support from family also played a great role.

Those who couldn't succeed are generally weak physically. They couldn't retain their knowledge. Some of them have house far away from bazar, union parishad, hospital, etc. for marketing their products.

Conclusions and Recommendations

Although the intervention is comparatively newer in outset and shorter in duration, there were visible outcomes both on women and children. There were positive achievements in terms of feeding practices, care to children, hand washing practices, immunization, use of iodized salt, vitamin A supplementation, etc. However, the most difficult part is, due to their low income, a large proportion of them are still adopting their previous practices, and going to medically non-competent peoples for treatment of diseases. They still practice of giving honey, cow-milk, warm water, etc. after birth of newborn. Perhaps, the reason is tradition. They couldn't come out of the tradition in such a small time. In Nutrition Pilot areas the women are starting semisolid foods at an earlier age. Probably, this element need more support and discussion from Nutrition Pilot for their understanding and acceptance.

Relatively low rate of full immunization in women and children in Intervention and far lower in Comparison and Control areas suggests the need for more awareness raising activities on this.

In light of the above, following recommendations can be made:

- Additional activities like communicating the message in meetings, trainings and seminars are needed. These activities needs to be carried out by knowledgeable and competent persons who can easily communicate with rural people.
- It would be appropriate to involve local opinion leaders like-- member, chairman, imam, teacher, matbor, for wider dissemination of health and nutrition messages. More often these opinion leaders are gatekeepers who hold enough influence on the community.
- The area coverage of training (Nutrition Pilot) needs to be increased. More training in a short time will bring more achievement, especially where the achievement is low and community support is needed.

- More women should be included in the trainings. Making women available for training is not an easy job. Therefore, enough motivation needs to be there so that women are convinced about short and long term benefits of trainings.
- Benefits of small family should be stressed in the trainings. Audio-visual materials are abundantly available on the benefit of having small family and how to keep family small. These materials can be made available to the members in intervention areas.
- The issue of going to medically competent person (doctor, paramedic) for health care, and in addition supply of medicine free or at low cost should be given emphasis. Community fund can be created or they may be included in a insurance system for this purpose.
- Campaign on exclusive breast-feeding should be promoted further for infants with due attention.
- Enhance awareness of full immunization of women and children, e.g. 5 TTs, BCG & full dose of DPT, Polio. Specific information should be provided in this respect regarding what is meant by full and partial immunization.
- Improve awareness about timing of weaning with inclusion of examples of local foods. How to identify those foods or its sources, where to have it, how to use for best results are some of the issues that needs to be tackled in awareness campaign.
- Local level volunteers should be created for wider dissemination of information, and repeating the training on sustained basis.