# Final Report on the Growth Monitoring Promoter Pilot Assessment

## Introduction

Bangladesh, a South-Asian developing country, has been paving its way to becoming a member of the global middle-income cohort. In the post-liberation era, the country has shown remarkable progress in several global development indicators, including health and nutrition. According to Bangladesh Demographic and Health Survey (BDHS) data, there has been a steady decline in the prevalence of stunting (low height for age) among children under five years of age, from 55 percent in 1997, to 41 percent in 2011, to 36 percent in 2014 and 31 percent in 2017[1]. The country is on track to further reduce stunting to 27 percent, as was set in the Sustainable Development Goal (SDG) target by 2025 (tentatively),[2] Achieving the SDG target is associated with better nutrition in Bangladesh, and will require collective actions and coordinated efforts.

A strategic review by Ahmed (2017) argued that addressing only poverty will not result in improved child undernutrition[3]. However, data in the BDHS revealed that 40 percent of children whose mothers are in the lowest wealth quintile are stunted, compared with 17 percent of those in the wealthiest quintile[4]. Similar to stunting, the poorest households are also more likely to have underweight children (low weight for age). Among other divisions in Bangladesh, Sylhet has the highest prevalence of stunting[5].

Strengthening Household Ability to Respond to Development Opportunities (SHOUHARDO[6]) III is a Development Food Security Activity (DFSA) funded by the United States Agency for International Development (USAID) and the Government of Bangladesh. The program is implemented in eight northern districts of Bangladesh including four districts (Kishoreganj, Netrakona, Habiganj, and Sunamganj) in the Sylhet division where acute malnutrition is one of the major challenges. The program has been providing health and nutrition counseling services to improve the knowledge of pregnant women and mothers of children under five on feeding and hygiene practices. Growth Monitoring Promotion (GMP) is one of the program interventions aimed to generate a positive outcome in this area. Growth monitoring and promotion is a process used to monitor children to ensure that they are reaching optimal growth. Growth monitoring is conducted by weighing of children under five years in either community health facilities or in community groups. Mothers and care givers are provided group and/or individual counseling on feeding practices and basic health-promoting practices.[7] GMP programs have been implemented globally for several decades now. Despite varying evidence of effectiveness, GMP is being implemented in 178 countries as part of the public health care service delivery and is perceived as critical to improving child health and nutrition.[8]

SHOUHARDO III contributed to improving the nutritional status of its participants in the last four years. According to the Participants Based Sample Survey (PaBSS) 2019, 59 percent (516 of 874) of the mothers (of children aged 6-23 months) confirmed their children were receiving Minimum Dietary

[1] https://www.researchgate.net/publication/337680718_Bangladesh_Demographic_and_Health_Survey_BDHS_2017-18_Key_Indicators_Report, cited on 2 July 2020.
[2] https://www.unicef.org/evaldatabase/files/Nutrition_Evaluation_Report_Vol_I.pdf, cited on 29 June 2020.
[3] https://www.researchgate.net/publication/312972319_Strategic_Review_of_Food_Security_and_Nutrition_in_Bangladesh, cited on 28 June 2020.
[4] https://www.researchgate.net/publication/337680718_Bangladesh_Demographic_and_Health_Survey_BDHS_2017-18_Key_Indicators_Report, cited on 2 July 2020.
[5] Ibid
[6] https://www.carebangladesh.org/shouhardoIII/, cited on 3 July 2020.
[7] https://academic.oup.com/jn/article/150/2/192/5585427, cited on 29 June 2020.
[8] Ibid.

Diversity (MDD)[9]. The program made progress in ensuring Minimum Meal Frequency (MMF[10]) for children in targeted households. Results from the PaBSS (2019) suggested that 49.9 percent (436 of 874) children in the participating households received MMF (against a target of 50%). Findings from FLAIRb[11] suggested that the percentage of children aged 0-6 months with exclusive breastfeeding and children aged with the early initiative of breast milk increased over the five rounds of the study.

To sustain these positive results, the program kicked-off three service model pilots, including the Growth Monitoring Promoters (GMPs) in October 2019. The GMPs offer growth monitoring and promotion services in exchange for a small fee. This report offers a comprehensive overview of the GMPs pilot assessment. The report starts with a positive note on the progress made in health and nutrition nationally as well as in the program implementing areas, and sets the background for the assessment. Then, the methodology is explained, followed by the findings. The last part of the report analyzes the findings and suggests areas of improvement.

## Background of the Study

In its two-year extension proposal, the program defined the Growth Monitoring Promoters as Licensed Service Providers (LSPs) who will:

*"Provide door-step growth monitoring services and sell different nutrition and hygiene commodities as an income-generation activity (IGA), one of the two LSPs planned for achieving health and nutritional outcomes by the programs."*

The technical proposal also stated that,

*"In FY20, CARE will train GMPs to provide growth monitoring services, including counseling to ensure children grow appropriately. GMPs will continue to provide growth monitoring services on a fee-for-service basis to sustain the long-term provision of services. CARE will ensure appropriate linkages of these service providers with MH&FW so that government-paid health staff takes on the responsibility of providing technical support to GMPs, assuming full responsibility after program phase-out. GMPs will also be linked with the private sector to provide some commodities for sale and business."*

According to the Nutrition Profile of Bangladesh[12] (2018) published by USAID, about fifty percent of pregnant women suffer from anemia. According to iccdr,b[13], around 450,000 children in Bangladesh[14] suffer from acute malnutrition. SHOUHARDO III has been working in hard-to-reach areas that are also prone to natural disasters, and as a result, these problems are even more severe in the program implementing areas. Some of the major problems include a critical shortage of trained health service providers, inequitable access to health care for people living in the program implementing areas, and high out-of-pocket expenditures[15]. Implemented properly, Growth Monitoring and Promotion is an important activity to promote nutrition and optimal among children age 0-59 months. GMP helps the

[9] MDD is defined as four or more, out of seven food groups including grains, legumes, dairy products (only for non-breast-fed children), fleshy foods, eggs, vitamin-A, fruits, and vegetables for children aged 6-23 months.
[10] Proportion of breastfed and non-breastfed children 6-23.9 months of age who receive solid, semi-solid, or soft foods or milk feeds the minimum number of times or more.
[11] Fostering Learning and Adaptation in Resilience Building (FLAIRb) is a longitudinal study initiated by SHOUHARDO III that started in July 2017 and ended in July 2019.
[12] https://www.usaid.gov/sites/default/files/documents/1864/Bangladesh-Nutrition-Profile-Mar2018-508.pdf, cited on 12 April 2020
[13] https://www.icddrb.org/, cited on 3 July 2020.
[14] https://www.icddrb.org/news-and-events/press-corner/media-resources/malnutrition, cited on 12 April 2020
[15] https://apps.searo.who.int/PDS_DOCS/B5409.pdf, cited on 12 April 2020

mother of children aged 0-59 months to follow her child's growth, and to practice optimal Infant and Young Child Feeding (IYCF) and time-based referral for treating illness. The Ministry of Health and Family Welfare (MoH&FW)[16] provides these services from all community clinics in Bangladesh. SHOUHARDO III identified 122 community clinics in 122 villages (out of 947) where the program is implemented. Though children in these 122 villages have been receiving GMP services, the remaining 825 communities lack access to GMP services.

As both an exit strategy and also to ensure that all communities are able to access GMP, the program developed and tested a specific sector of LSPs known as 'Growth Monitoring Promoters (GMPs)'. The GMP is one of the LSPs that will continue GMP services within their catchment areas (consisting of one or more communities). The GMPs were self-selected and included women who had an interest in being small business entrepreneurs. Most of the GMPs had community acceptance and some (limited) knowledge of health and nutrition services. GMPs provided fee-based services often decided by themselves and the community people. The program trained a total of 64 GMPs in 16 villages in both the char and haor regions. The GMPs conducted growth monitoring services and nutrition counseling for pregnant women and breastfeeding mothers in their communities. They also offered need-based referral services for mothers and children who were malnourished. The piloting locations were selected based those areas where growth monitoring and promotion services offered by the Ministry of Health and Family Welfare (MoH&FW) did not exist.

The program did monthly follow-ups with most of the GMPs (those available on the phone) and found that the GMPs received varied service charges from the pregnant women and lactating mothers that they served. The GMPs earned BDT9.12 (0.11 US on average) per visit for per person receiving the GMP services during the piloting period. A total of 64 GMPs served 5,358 children and pregnant women and they earned a total of 590.25 USD during a three month period (January – March 2020)[17].

One of the positive findings was that the GMPs were connected with the nearest community clinics, Upazila Health Complex, local doctors, community health volunteers, and drug stores. During monthly follow-ups with GMPs, some shared that they assisted the lactating mothers to get vaccinated from the community clinic. It was inspiring to know that one of the GMPs from haor saved her income to buy medical equipment and attend training.

As of March 2020, most of the GMPs were struggling to obtain service charges from the pregnant women and lactating mothers that they had served. In both char and haor regions, there was a gradual decline in the monthly income of the GMPs. In char, a new health program was initiated during the pilot phase that worked as disincentive and reduced the fee-based service seeking behavior of the pregnant women and lactating mothers. In both char and haor other development projects were offering similar service at free of cost with other benefits hence the number of pregnant women and breastfeeding mothers that took service from the GMP gradually declined. In haor, total monthly income for 12 GMPs was 60.67 USD during the first round of follow-up which fell to 17.86 USD in the fourth follow-up done with 10 GMPs. Similarly, during the first follow-up, total monthly income for 16 GMPs was 45.88 USD in char whereas 11 GMPs earned 28.49 USD during the fourth round of follow up. Finally, the GMPs shared their concern about earning insufficient income and the need to diversify their services. They were willing to enhance their capacity and start selling essential drugs (e.g. Iron Folic Acid supplements, vitamin tablets, drugs for fever and pain, birth control pills) to increase their income.

[16] http://www.mohfw.gov.bd/, cited on 2 July 2020.
[17] Source: 4th round follow-up findings report.

## Objectives

The goal of the assessment was to assess the effectiveness of the GMP fee-for-service model and identify specific areas of adjustments prior to taking the model to scale. Specific objectives included:

(a) To assess the GMP pilot and its outputs as were planned/designed initially
(b) To identify good practices and areas of improvement for the pilot
(c) To inform scale-up strategy by providing specific recommendations

## Methodology

The design of the GMP pilot assessment took into account the purpose of the pilot, and the limitations of investigation due to COVID 19, and then considered the appropriate methodological ways of inquiry[18]. The assessment used a mixed approach but was primarily qualitative in nature, using both semi-structure interviews and focus groups, with both tools using quantitative and qualitative questions.

*Study Location and Sample Selection*

The study location was determined by the pilot design directing statistically significant results[19]. The study areas encompassed 21 Unions in the four Upazilas where the pilot was implemented. The study population included the GMPs, pregnant women and mothers of children under five years of age that purchased services from the GMPs, and relevant stakeholders (from the government). A total of 32 GMPs, 32 pregnant women, and mothers of children under five were randomly selected from 21 Unions. Eight stakeholders[20]were purposively selected based on their availability. Three of the 72 respondents were male (4.17%) and the rest were female (95.83%).

*Data Collection and Assessment Tools*

Data collection was conducted by a team consisting of the program's senior staff. They received an orientation on remote data collection and guided by the program's Senior Technical Coordinator – Health & Nutrition and Senior Coordinator – Program Quality & Research. Two Senior Technical Managers (STM) and four Senior Officers (SO) were engaged in the data collection for this pilot assessment. The assessment was implemented remotely in response to the pandemic situation. Verbal consent was obtained from all study participants as part of ethical consideration. In total, 40 interviews were conducted with GMPs (32) and the stakeholders (8) to obtain a deeper understanding of the progress, results, opportunities, and challenges associated with the pilot.

The data were collected through semi-structured interviews and Focus Group Discussions (FGDs), and both the interviews and the focus group discussions were conducted through phone calls. The insights and suggestions from the community accessing services, especially pregnant women and mothers of children under five, were captured through eight FGDs. The interview tool was a semi-structured questionnaire entailing both quantitative and qualitative questions. A similar type of tool was applied for the FGDs. Although, FGDs are typically conducted using a checklist, in this case, the team had limited choice as they were done over the phone. The data collection tools were primarily developed based on the indicators set while designing the GMO pilot. The indicators included:

- The proportion of households that paid the full user fee for GMP services
- Monthly income of the GMPs from service provision
- Number of children reached each month by GMPs

[18] https://pdfs.semanticscholar.org/7c1e/6049ef380fab2ea671fa63b14caf29dfe9d6.pdf, cited on 29 June 2020
[19] The geographical location for this pilot is precisely detailed out in the pilot design (Annex 1).
[20] Four of them were Community Health Care Providers (CHCP), two of them were Family Welfare Assistants (FWA) and two of them were Health Assistants (HA).

- Remoteness in terms of the availability of health and nutrition services and transportation
- The motivation of the Growth Monitoring Promotors to continue GMP services
- Barriers faced by the Growth Monitoring Promotors
- Service quality as perceived by community members
- Horizontal and vertical linkages between GMPs, communities, and GoB health services
- Level of awareness of community clinics and staff on the importance of Growth Monitoring & Promotion services
- Support provided by MoH&FW to Growth Monitoring Promotors

The tools were revised and refined multiple times based on the feedback of the data collectors and responses from the study participants. To ensure the convenience of the respondents, data was collected through scheduled interviews; priority was given to respondents' preference of time. Some of the interviews were completed through multiple phone calls as the respondents had to engage in caregiving roles in between (e.g. looking after their children).

The data were analyzed using thematic categories that emerged through the data collection process. The analysis considered the success factors included in the original design of the pilot. The qualitative data were analyzed under thematic categories and sub-categories through spreadsheets. The process was undertaken following some steps – (i) data and responses were thoroughly reviewed to gain a clear knowledge on what has been saying; (ii) organized responses to put them under the thematic categories; (iii) added sub-categories, organized and coded responses under them; and (iv) responses were double-checked and some of them were re-organized to have precision. The analysis also looked into connections between the findings and the program's Theory of Change.

## Findings

This part of the report presents empirical data collected for assessing the GMP pilot and explains the findings. This section is divided into two parts: A. Findings from the supply side; and B. findings from the Demand Side

### A. Findings from the Supply Side

Findings from interviews with GMPs are disaggregated in to six broad thematic areas, including (i) service provision, (ii) income, (iii) their knowledge on the local health care service providers (iv) horizontal and vertical linkages, (v) motivation, and (vi) challenges.

### (i) Service provision

**Service coverage:** Approximately 50.0 percent [16 out of 32, 50%] of the GMPs reported providing growth monitoring and promotion services in one village only, 28.1 percent [9 out of 32, 28.1%] GMPs served in two villages, 18.8 percent [6 out of 32, 18.8%] GMPs provided services in three villages, and 3.1 percent GMP [1 out of 32, 3.1%] served in four villages.

**Client-base:**

Pregnant Women

Approximately 84.4 percent [27 out of 32, 84.4%] of the GMPs served an average client-base of 1-15 pregnant women per month. Nearly 15.6 percent [5 out of 32, 15.6%] of the GMPs served 16-30 pregnant women per month.

Lactating women and children under 5

Around 46.9 percent [15 out of 32, 46.9%] of the GMPs provided services to 16-30 children (under 0-59 months) per month, and 34.4 percent [11 out of 32, 34.4%] of them served around 1-15 children (under 0-59 months) in a month. Three [out of 32, 9.4%] GMPs served 31-45 children on an average, 6.3

percent [2 out of 32, 6.3%] GMPs served above 60 children, and 3.1 percent [1 out of 32, 3.1%] GMP served 46-60 children (under 0-59 months) in a month.

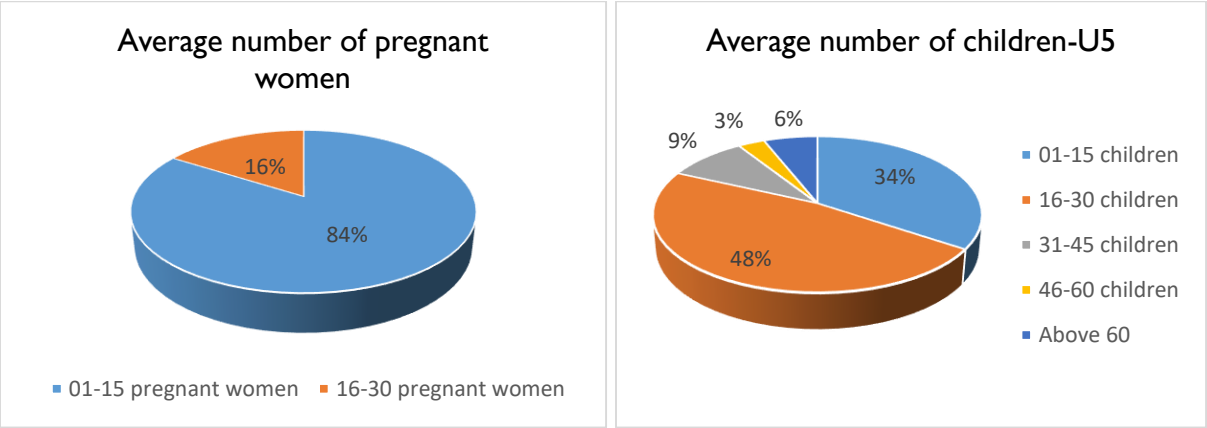


Figure 1: Percentage of GMPs and their client-base (average on a month)

### (ii) Monthly income

**Monthly income:** About 59.4 percent [19 out of 32, 59.4%] GMPs reported earning 0-2.42 USD per month from providing growth monitoring services to children and pregnant women. The average monthly income for 34.4 percent [11 out of 32, 34.4%] of the GMPs ranged between 2.43-6.04 USD. 3.1percent [1 out of 32, 3.1%] GMP's income was within the range of 6.05-8.45 USD and another 3.1percent [1 out of 32, 3.1%] GMP earned above 12.08 USD in a month from her services.

**Income spending areas (main uses of income):** The majority [23 out of 32, 71.9%] of the GMPs shared that they mostly spent the service charges earned from GMP services on their children, 56.3 percent [18 out of 32, 56.3%] of the GMPs spent on other family needs, 37.5 percent [12 out of 32, 37.5%] of the GMPs saved their income, and 31.3 percent [10 out of 32, 31.3%] of the GMPs spent this earning on their own personal needs. Six [6 out of 32, 18.8%] GMPs invested their earning on small business, three GMPs [3 out of 32, 9.4%] gave their income to their husband or other family members, and two GMPs [2 out of 32, 6.3%] spent on other purposes, for example, agricultural and livestock.

**Other income sources:** Nearly half [15 out of 32, 46.9%] of the GMPs reported that they had other income sources and 53.1 percent [17 out of 32, 53.1%] of the GMPs did not have any other income source.
Among the 15 GMPs who had other income sources, five of them were involved in tailoring and four of them were working in BRAC. The other respondents mentioned selling health care products (i.e., birth control injections, essential drugs), working at local NGOs (i.e., DSK), working at the local dairy farm, working at their poultry farm and grocery shop.

**Average monthly income from other sources:** Among these 15 GMPs, two had an average monthly income between 144.88-181.10 USD from the other income sources. Two GMPs reported earning 181.10 USD, on average. Each of three GMPs earned around 72.44 USD, 60.37 USD, and 48.30 USD, respectively, from other sources. However, two [out of 15] GMPs earned 24.15 USD and three [out of 15] GMPs earned 18.11 USD on average in a month. Each of three GMPs earned 3.09 USD, 2.42 USD, and 1.82 USD respectively from other sources in a month.

### (iii) Knowledge of the local health care service providers

**Health care providers:** Around 41 percent [13 out of 32] of the GMPs stated that they knew about their community clinics (1-5 kilometers away) and another 41 percent mentioned the Health Assistants (HA) working in their areas. Family Welfare Assistants (FWA), BRAC health workers and village doctors

were mentioned by 6 [out of 32] GMPs and 16 percent [6 out of 32] GMPs mentioned Upazila Health Complex. Others mentioned about EPI center and family planning staff, Union Family Health and Welfare Centre, Community Health Care Provider (CHCP), POPI and Swanirvar (a local organization).

### (iv) Horizontal and vertical linkages

**Connection with health care providers:** More than half [17 out of 32, 53.1%] of the GMPs were connected with Community Health Care Providers (CHCP), 21.9 percent [7 out of 32, 21.9%] of the GMPs were connected with health service providers from other NGOs. Each of the six [6 out of 32, 18.8%] GMPs were connected with doctors/staff from Upazila Health Complex and Community Clinic respectively. Moreover, each of the two [2 out of 32, 6.3%] GMPs mentioned that they had a functional relationship with the village doctor, pharmacies/ local drug store, and EPI center.

**Assistance from health care providers:** Among the GMPs, 59.4 percent [19 out of 32, 59.4%] received assistance from the health care providers in their areas, while 34.4 percent [11 out of 32, 34.4%] GMPs did not receive any assistance. Two [out of 32, 6.3%] GMPs did not respond to this question because they did not require any assistance from health care providers. The GMPs reported receiving different types of assistance from the local health care providers. Five [out of 19] GMPs received vaccines and family planning-related support from the health care providers in their areas. Among other assistance, four GMPs [out of 19] received IFA supplements and five [out of 19] GMPs assisted during Vitamin-A campaign. Three [out of 19] GMPs received supports and services (ensure checkups) from the community clinic staff for pregnant and lactating mothers who were referred by the GMPs, and four [out of 19] GMPs disseminated information on the number of malnourished infants, children, and pregnant women while the health care providers visited their villages.

**Connection with other GMPs:** Most [75% out of 32] of the GMPs were connected with other GMPs. However, six [out of 32, 6.3%] GMPs were not connected with other GMPs.

**Connection with and support from SHOUHARDO III staff:** All 32 GMPs reported being connected with the SHOUHARDO III staff. The majority [24 out of 32, 75%] of the GMPs shared that the SHOUHARDO III staff introduced them to the community people as service providers, attended and overserved the GMP sessions, provided five day trainings and technical advice, shared necessary information, assisted scheduling the sessions, motivated the community people to receive GMP services on a fee basis, and helped with recordkeeping in the register. Five [out of 32, 15.6%] GMPs reported not receiving enough support from the SHOUHARDO III staff. One of the GMPs from Dhaki, Mithamain Upazila shared that, "*SHOUHARDO III staff, especially the FTs are always busy with their assigned work and no scope to support the GMPs*."

### (v) Motivation

**Motivation to work as GMP:** Nearly 68.8 percent [22 out of 32, 68.8%] of the GMPs mentioned financial independence as their motivation to work as a Growth Monitoring Promoter, 65.6 percent [21 out 32, 65.6%] shared their commitment to serve the community, and 46.9 percent [15 out of 32, 46.9%] stated they were motivated by respect from their community. Around 43.8 percent [14 out of 32, 43.8%] shared that they were motivated by their family members. The GMPs also mentioned about being empowered and their passion for this work.

**Support from family members:** Around 87.5 percent [28 out of 32, 87.5%] of the GMPs received support from their family members while working. The GMPs reported being encouraged by their family members while providing the services. The GMPs shared that their mothers-in-law and husbands help them with household chores and took care of the children while they worked. They also received emotional and financial support from their family members. On the contrary, four [out of 32, 12.5%] GMPs were deprived of their family support. One GMP shared that her husband is a village doctor and he discouraged her work due to the poor income from growth monitoring and promotion service.

| Nadira's Story: Small steps to making big differences |
|---|
| Nadira Akter from Mithamain providing GMP services, nutritional counseling, advice on health, and hygiene practices. Her clients reported being benefitted from Nadira's services and willing to pay her. *"Many of our mothers-in-law told us to not give specific food to our children due to prejudices. Because of Nadira apa we realized the importance of nutritious food for our children,"* shared by a mother. Other than her regular services, Nadira assisted families in accessing better treatment. With her support, a little girl suffering from pneumonia received treatment from Mithamain Upazila Health Complex, where she's well-connected with the doctors. She faced some obstacles while serving the community - for example, due to the lack of GMP cards she had to provide handwritten notes to her clients. She said that if she could purchase some equipment (i.e. sphygmomanometer, thermometer, glucometer, and pregnancy kits) and provide essential drugs (for fever, diarrhea, and painkiller), IFA and calcium supplements,she would be able to do more to help the community.,She saved her income from the GMP services to purchase a sphygmomanometer and the local drug seller promised to teach her to use the equipment. Besides working as a GMP, she earns some money from tailoring and tutoring that supports her living. |

**Support from community members:** More than half of the [21 out of 32, 65.6%] GMPs received support from the community members while working as a GMP. They shared that community people highly appreciated their services as well as the advice provided by the GMPs. They also assisted the GMPs to conduct their sessions and disseminated information on their behalf. Nine [out of 32, 28.1%] GMPs said that they did not receive any support from the community members, and two respondents did not respond to this question.

### (vi) Challenges/ barriers

Studies of two large-scale programs[21] in Bangladesh found that Growth Monitoring has little or no effect on improving child growth, particularly if monitoring is not accompanied by nutrition counseling. Additional reasons include poor performance among growth monitors, and the inadequate healthcare system and infrastructure to support growth-promoting action[22]. These factors may have partially contributed to the low participation by the community in fee-for-service GMP. About 59.4 percent [19 out of 32, 59.4%] of the GMPs reported facing challenges while working as a GMP. Alternately, 31.3 percent [10 out of 32, 31.3%] of the GMPs didn't face any kind of challenges while serving their communities.

Specific challenges were uncovered. Nearly half [14 out of 32, 43.8%] GMPs experienced difficulties in receiving payment and 10 [out of 19] GMPs faced transport-related difficulties. Some of them [7 out of 19] reported that the community had diversified demands for services. They also shared that, due to other GMP service providers from GoB and other NGOs providing free services, GMP's clients were not willing to pay for services. Six [out of 19] GMPs struggled to manage their time for providing services. One of the GMPs from Eloenguri, Itna Upazila shared her challenges, "*Earlier I served as a CHV, now communities aren't interested to receive paid services. On the other hand, Surjer Hasi (Swanirvar - NGO) also working in this area. The Field Trainer (FT) is also aware of my difficulties, but no one communicated with me.*"

Among the 19 GMPs who reported facing challenges, only three took action to resolve it. They tried to convince their communities of the positive aspects of the GMP services, despite their reluctance to receive paid services from the GMPs. The GMPs also sought support from SHOUHARDO III staff (Field

[21] Bangladesh Integrated Nutrition Project (BINP) was implemented by the Government of Bangladesh Ministry of Health and Family Welfare between 1996 and 2002; and growth-monitoring program carried out by Bangladesh Rural Advancement Committee (BRAC) in 1987.

[22] https://onlinelibrary.wiley.com/doi/full/10.1111/j.1740-8709.2007.00125.x, cited on 30 June 2020.

Trainers) to motivate the communities to pay the service fee. The rest did not take any actions to address challenges that they faced while providing services.

### (vii) Recommendations from the GMPs

1. The GMPs recommended that the program to mobilize communities in favor of fee-for-service model.
2. Regarding the fee-for-service model, one GMP commented, "*Earlier services were provided by the paid volunteer, but now we are working with the community, they should be aware of their contribution (paid services)*."
3. The GMPs requested more training and equipment for measuring blood pressure, blood sugar tests, ANC and PNC services, pregnancy kits, IFA supplements, and essential drugs for communities. "*After weighing the pregnant women, they always say that it'd great if I could measure their blood pressure. For this five minutes task they need to travel almost two hours to visit the Upazila health complex*" shared by Kakoli a GMP working in Itna Upazila
4. Additional recommendations were that the current GMPs can train potential GMP service providers.

### (viii) Perceptions of Growth Monitoring Promoters

Another dimension of the supply side was added from the insights of the stakeholders. This part of the report focused on their knowledge and perception of GMPs, and potential support geared to sustain the GMP fee-for-service model. Eight stakeholders (four Community Health Care Providers, two Health Assistants, and two Family Welfare Assistants) were interviewed from four Upazilas including Nageshwari, Phulbari, Itna, and Mithamain.

All eight respondents reported being aware of the service provided by GMPs in their areas. All the respondents believed that the GMPs added value to the community by providing GMP services and referals to Community Clinics.

The stakeholders shared that the GMPs were continuously adding value to the local health care facilities. According to them, the GMPs provided door-to-door GMP services and GMP at EPI centers; they measured and recorded the weight of under-five children and pregnant women; they suggested pregnant women take rest, consume additional food, and attend regular checkups during pregnancy; and they provided counseling to receive ANC services from the community clinic. The stakeholders also mentioned that GMPs counsel the mothers on exclusive breastfeeding, child care, complementary feeding, and immunization, and that they referred the sick children to the community clinic. One of the stakeholders stated that the GoB could not provide services to all the children under five and adolescent girls, and the GMPs played a vital role in closing the gap in health care services.

Some of their suggestions included:

1. Training GMPs as skilled birth attendants (SBA)
2. Training GMPs on how to measure blood pressure (BP), and provide them sphygmomanometer
3. Training GMPs to provide treatment with the necessary equipment and basic medicines.

The stakeholders expected better coordination from the GMPs in organizing health sessions at the EPI center on EPI day. The also mentioned initiatives that their organizations could take to improve the capacity of the GMPs. They were willing to provide training (mostly on-the-job training) and include GMPs in different national campaigns (i.e., upcoming Measles-Rubella campaign, Vitamin A campaign, deworming week).

## B. Findings from the Demand Side

On the demand side, program participants' perspectives are captured through FGDs explained below. This part of the report highlights

(i) level of awareness,
(ii) willingness to pay, and
(iii) community perception.

The following findings were generated from eight FGDs with pregnant women and lactating mothers. Four or more people participated in each FGD. The respondents participated from different villages of eight Unions including Baro Bhita, Bhangamore, Rayganj, Ballabherkhas, Elongjuri, Mrigha, Bairati, and Katkhal under four Upazilas that included Phulbari, Nagashwari, Itna and Mithamoin.

### (i) Level of awareness

In Bangladesh, nutritional challenges begin from the moment of conception to childbirth, and it continues with low birth weight followed by limited access to nutritious foods and poor dietary practices. According to a survey conducted by UNICEF, mothers' awareness has an important connection to children's nutrition status[23]. Respondents from all eight groups reported that they were well informed about the services provided by the Growth Monitoring Promoters (GMP) in their areas. All of them considered the service important for them and their family members. The respondents highly benefitted from the services as they were informed about their health condition as well as their children's nutritional status and growth. In the case of a sick child, they could take appropriate measures immediately for improvement such as taking extra care, feeding nutritious food, going to the clinic/hospital if required. "*I didn't know about the importance of growth monitoring while I was pregnant for the first time. I didn't track the growth and could not manage to eat sufficiently. Eventually, the child was born malnourished and I became weak after giving birth. However, now I know how to track the growth of the child and I took the service during my last pregnancy*" shared Joni Rani Paul, one of the FGD respondents from Itna. The respondents appreciated the fact that they could receive the service at their door-step. In addition, they received nutritional counseling and information on health and hygiene issues (hand-washing, personal hygiene care) from the GMPs. The GMPs also suggested they visit the nearest health care facilities when needed.

### (ii) Willingness to pay

All the respondents (from eight groups) expressed their willingness to continue paying for the GMP services that they received from the GMPs. The respondents explained that they would be willing to continue paying for the GMP services because they received services at their community level. Another reason was that they could get information about the health and nutrition status of their children by paying a small amount of money from the GMPs. Respondents from four [out of eight] groups shared that they would like to pay 0.13 USD on an average for the services each time.

> Ayrin, one of the FGD participants said that "*If my child grew up in good health, spending 0.13 USD doesn't matter to me*." Respondents from three [out of eight] groups shared that they would like to pay 0.24 USD on average for the services for the same service. "*Though I haven't paid her yet, I am ready to pay her 0.24 USD if she provides regular and quality service*" shared Mariya, a lactating mother from Itna, Kishoreganj.
>
> Another participant named Shahina stated that "*0.24 USD is not a big amount, it is more important that we get this opportunity to know about our children's health status (good or bad) and take*

[23] https://www.unicef.org/bangladesh/en/maximising-growth-children, 29 June 2020.

*appropriate measures*". "*As I can get an update on my child's health condition through this service, I am agreeing to pay as much as the service provider wants, however, considering my current financial condition, it would great not to pay more than 0.24 USD for each service*", Shuvotara from Mithamain asserted while sharing her thoughts on payment.

On the contrary, some respondents expressed their reluctance to pay the service providers due to poverty and free services provided by other NGOs (i.e., BRAC health workers). One of them believed that they should not pay the GMP rather she (GMP) should be paid by the NGOs. According to her, there are free services like growth monitoring promotion in nearby areas. One participant from Mithamain stated that "*There's no need to pay for the services*!"

### (iii) Community perception

The respondents from all groups reported that they were satisfied with the quality of services received from the growth monitoring promoters.

"*There is no hospital nearby and the health service providers are also not available. So, this type of service is really helpful for us. Most importantly, we can know the health condition of our children with their help*" shared Mariya, one of the FGD respondents from Kishoreganj.

Another respondent named Taslima shared, "*She can only take the weight of pregnant women and children which helps us understand the growth and nutrition status of the children*."

One of the female FGD respondents stated, "*I can track the growth status of my child with the help of GMP. If she's (baby girl) underweight compared to her age, I can take care and feed my daughter nutritious food which I usually try to feed her.*"

Respondents suggested diversifying GMPs' services including measuring blood pressure, measuring body temperature, blood sugar testing, pregnancy test (using strips), ANC service, IFA supplement, family planning products, and treatment for common diseases and illness (fever, headache, cold, dysentery, and worm infections) and prescribing basic drugs. They preferred to receive these additional services from the GMPs since the health center and hospitals were far and the doctors were not available in their areas.

Rubi, a breastfeeding mother, and a respondent said, "*The community especially women can't usually go to the community clinic, hospital and dispensary at the Upazila level but they need some medicine such as iron-folic acid, vitamin tablet, calcium tablet and medicine for blood pressure regularly. These people won't mind paying a bit more to her (GMP) if they get the medicine at home*."

## Analysis

Growth Monitoring and Promotion as a community-based nutrition activity plays a vital role in promoting health and nutrition knowledge through education and mobilizing communities[24]. The key objective of this assessment was to assess a fee-for-service GMP model.. While designing the pilot, some success factors were determined during implementation of the pilot. These included:

(i) sufficient income to motivate GMPs
(ii) (ii) community acceptance of the model
(iii) (iii) recognition and support from the MoH&FW, and

[24] https://www.researchgate.net/publication/8779015_Acceptability_of_Community-Based_Growth_Monitoring_in_a_Rural_Village_in_South_Africa, cited on 29 June 2020.

(iv) (4) standard of services Provided

The majority of these success factors are subjective in nature and difficult to assess without having a specific definition. Nevertheless, it is possible to draw insights on perceived 'sufficient' income, 'acceptance', and 'standard of services' based on findings.

The income of the GMPs largely depended on communities' willingness to pay for their services. The majority [19 out of 32] of the GMPs earned up to 2.42 USD in a month and the rest [11 out of 32] earned as much as 6.04 USD. This income may not be significant, however, must be interpreted as an 'additional' income for nearly half of them [15 out of 32]. The others struggled to continue providing services and earning income in the presence of other service providers offering similar services and better incentives[25].

Lack of diversity in their services was another reason for earning a relatively poor income for the GMPs. The target population of the GMPs has been going through a transition from being 'program participant' to being 'clients'[26]. There are overlapping areas between both of these; however, the latter demands for addressing the socio-economic obstacles. The program may not call GMPs' income insignificant, as the pricing was done carefully by factoring in the ability of the target population.

When asked about their motivation to continue providing growth monitoring and promotion services, most of the GMPs mentioned their financial independence. Along with the diversification of the services, they sought further training to develop the expertise to continue providing services to the community. The stakeholders and the community echoed the same.

The reluctance of the community to pay for the GMPs' services was one of the major challenges throughout this pilot.The major factors contributing to this situation include:

(i) The community's lack of awareness on GMP services and the value of the services in improving mother and child nutrition and health outcomes;
(ii) The availability of similar services free of cost. Half of the communities agreed to pay the GMPs around 0.13 USD (each time they received the service) and less than half wanted to pay 0.24 USD.

The female respondents in the FGD (both pregnant and mothers) did signal their satisfactory attitude towards GMPs' services. However, to sustain this business model and continuously improving the quality of the service, The community members must be more aware of, and bought in to, the service.The more aware they are, the better they will be able to make the GMPs accountable and demand better services according to their needs. This kind of awareness will be essential once the program exits.

The stakeholders could play a key role in ensuring the quality of the GMPs' services. The stakeholders acknowledged the contribution of the GMPs in improving the health and nutrition status of the community and were willing to offer on-the-job training to the GMPs. This shows that the GMPs were successful in developing linkages with other service providers.

According to the program's Theory of Change, growth monitoring and promotion (along with other interventions) is expected to enhance the knowledge of households on dietary diversity for pregnant mother and children under five, and in turn, increase nutritious food consumption.. Findings from the FGDs and interviews suggested that pregnant women and mothers of children under five reported

[25] In the char region, another project named JOTNO provided free GMP services and cash incentive to pregnant women and mothers of children U<5.

[26] https://www.researchgate.net/publication/277965692_Making_Hybrids_Work, cited on 28 June 2020.

increased consumption of nutritious food. It was indicative of the fact that the community has gradually started realizing the value of Growth Monitoring and Promotion services.

**Implications of the assessment**

The GMPs, although faced with several challenges initially, managed to sustain some good results. Most of them earned money from providing GMP services. The community expressed a genuine interest in availing GMPs' services as they benefitted from these. The core challenges of this model is the willingness of the community to pay a small fee for service, particularly if other facilities/organizations offering similar services at free of cost.

Suggested revisions to the fee-for-service GMP model include:

- **Preventive approach:** Findings from the assessment revealed that both the GMPs and the community wanted more services than the ones currently provided. One of the ways to diversify GMPs' services and meet the community's need can be to scale up this is to merge this pilot with the Private Skilled Birth Attendant model [27](P-CSBA). By doing so, the program will not only roll out a demand-driven service model but also ensure a sustainability.

- **Community mobilization:** The GMPs struggles to obtain fees in several pilot locations. Although, the primary reason was the availability of free growth monitoring and nutrition counseling services offered by other development programs. Even if this pilot is merged with P-CSBA model, the program will need to mobilize community in favor of a fee-for-service model. The program may also consider providing training to the GMPs on community mobilization as they struggled in raising awareness on a fee-for-service model.

- **Capacity:** Follows up discussion, as well as the study findings, suggested that the Growth Monitoring Promoters struggled to get fees in exchange of their services as there were other organizations that provided the same service at no cost. It is highly likely that there will more development program offering services on health and nutrition issues and the program will not be able to protect GMPs from adversities always. While scaling up this model:
  (i)potential GMPs should be trained in marketing and sales by experts who have the experience and skills of doing this. Inclusion of gender and soft skills training for the GMPs would be valuable.
  (ii) If possible, the training should target a family member, preferably the husband so the GMPs experience less or no challenge from their family.
  (iii) Considering the current pandemic and its long-lasting impact on people's lives, the GMPs may need to develop skills on social media marketing[28] as a frugal solution in the context of Bangladesh where the use of technology has started unfolding in rewarding ways. On the ground it may mean for the GMPs to utilize mobile phone and internet to share the importance and availability of their services, or, connecting with tele-medicine service providers with the community.

- **Resources:** Going forward, the model must ensure the supply and availability of Growth Monitoring cards so that the mothers are able to keep the records of their child's growth status – the cards will also allow them to consult other household members on the child's growth, thus involving the whole family.

[27] Also piloted in selective SHOUHARDO III areas in haor. Report attached with this quarterly progress report.
[28]https://www.researchgate.net/publication/311802010_Social_media_marketing_as_an_effective_instrument_of_the_promotion_of_social_business-project_in_social_entrepreneurial_activity, cited on 2 July 2020

- **Service saturation and quality:** While scaling up this model, the program should do a thorough mapping of areas where facilities/organizations are offering similar services and avoid those to create space for GMPs; For SHOUHARDO III, as a dynamic program, it was critical to utilize lessons from the past[29] model of GMP (by CHVs) - the lessons should have been more integrating in to the design of this LSP-led service model. It will be useful for the program to develop a guideline that will demarcate steps to implement GMP along with suggestions on how to implement GMP in geography and cultural contexts of varied malnutrition prevalence.

- As suggested above, scaling up the fee-for-service model will require several adjustments. The following management function while scaling up this approach may be useful:

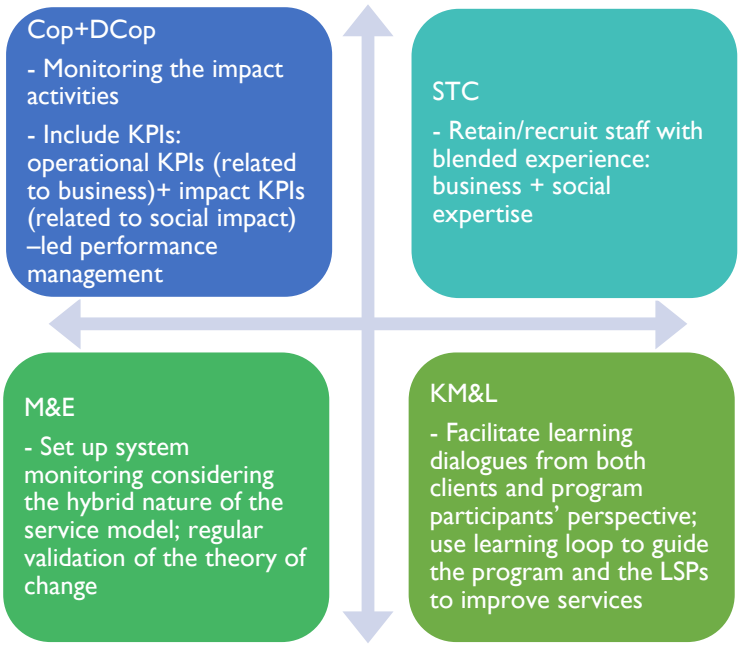


*Figure 1 Proposed management functions*

## Conclusion

In Bangladesh, the causes of poor health and nutrition status of rural women include lack of knowledge, poor sanitation and handwashing practices, lack of insufficient healthcare services, underlying illnesses, and socio-cultural factors – the status of women and girls in their family and society[30]. Despite the improvement in human development, child and maternal malnutrition remain a major challenge for the country to reach the 2030 Sustainable Development Goals[31]. As a result, the government of Bangladesh undertook the second National Plan of Action for Nutrition with a special focus to reduce children U<5 stunting to 25 percent by 2025[32]. To address gaps related to health and nutrition, SHOUHARDO III began piloting a fee-based growth monitoring promoter model.

[29] The mid-term evaluation report recommended (no.8) to improve the quality of GMP by establishing the importance of preventing child malnutrition, accurate anthropometric measurements, and functional referral system.
[30] https://journals.sagepub.com/doi/pdf/10.1177/156482659401500316, cited on 28 June 2020.
[31] https://www.ennonline.net/nex/10/nationalplannutritionbangladesh, cited on 29 June 2020.
[32] https://www.carebangladesh.org/upload/files/publication_1551604971_7.pdf, cited on 29 June 2020.

The assessment suggests that all the trained GMPs were able to provide services in their respective catchment areas, and to earn some money from it. The GMPs provided services up to four villages and earned as much as 6.04 USD per month. For about half of them, it was an additional income source. They reported financial independence as one of their key motivations, and the majority of them were supported by their family while providing services to the community.

Most of the GMPs developed connections with the local health care service providers. The GMPs were keen on providing more services to the community and sought support in terms of building their capacity and skills. .

The local stakeholders, in their interviews, shared positive insights on the GMPs and their contribution. They were willing to provide on-the-job training to the GMPs. The community participants were also pleased with the GMPs and their services. The majority of them were in favor of paying service charges to the GMPs.

However, one of the main challenges wasa the community's reluctance to pay for services due to the availability of similar services free of cost.

After analyzing the findings, the assessment enlisted some areas of adjustments for the scale-up strategy. The program may consider those for achieving sustainable results in health and nutrition. The study exits with several questions, including:

1. Will the Growth Monitoring Promoters keep serving the people that they are primarily supposed to serve while maintaining a balance of their desired income and their current income?
2. Will their service be only available to people who can afford it and leave out the most vulnerable ones?
3. Will the program be able to balance between the desired social outcome and financially sustainable service model?[33]

[33] Ibid.

## Annex 1: Piloting of Growth Monitoring Promotor

1. Summary description of what service models we are piloting

As Growth Monitoring and Promotion service is one of the important activities to promote nutrition among children age 0-59 months. It creates opportunity for a mother of children age 0-59 months to take appropriate measures, like, Infant and Young Child Feeding (IYCF) and time based referral for treating illness. Currently MoH&FW has been providing GMP services from all community clinics. SHOUHARDO III identified 122 Community Clinics in 122 villages. So, community children of these 122 villages are receiving GMP services. Rest of 825 communities don't have access to GMP services. This is a felt-need for those communities to get access to this services from the communities. As program's current GMP activity is considered as non-sustainable (service offered by program provided Community Health Volunteers) activity, it plans to initiate a new approach of developing some Local Service Providers (LSPs) who continue service provisioning for the communities. The Growth Monitoring Promotor is one of the Local Service Providers (LSPs) that will continue Growth Monitoring & Promotion (GMP) services within her catchment areas (consisting of one or more communities) that are reachable for her. The Growth Monitoring Promotor will be self-selected having interest to be small business entrepreneur, having community acceptance and some sorts of health & nutrition related knowledge and or skills. This provider must provide GMP services in charge of user fees determined by negotiation between community and her. Program will create demands for receiving GMP services from Growth Monitoring Provider.

2. Variables to be tested

After piloting, an assessment on 'How effective The Growth Monitor Promotor Model is' will be conducted: The variables to be set are as follows:

- What proportion of households offer user fee for receiving GMP services
- The projected monthly income from this service
- Number of projected children reached each month
- Remoteness in terms of available health & nutrition services
- Remoteness in terms of communication (distant and time of GM promotor to reach targeted case/beneficiary to provide services)
- Level of awareness of community clinic on importance of Growth Monitoring & Promotion services
- What extent of support provided by MoH&FW to Growth Monitoring Promotors to continue GMP services
- What factors motivated Growth Monitoring Promotors to continue GMP services
- What barriers hindered her to do her job
- Service quality
- Horizontal and vertical linkage

3. Sampling approach [How many and how the villages are selected; the service providers selected for the pilot; other qualifying aspects eg skills, market access etc] [clarify for each variable to be tested above]

a) Geographic location: Total number of piloting villages are 16 (For statistical significant result, at least 16 numbers can be considered)

- Haor region: 8 villages (4 villages in Baniachang upazila, Hobiganj) and 4 villages in Mithamoin, Kishoreganj)

- Char region: 8 villages (4 villages in Nageswri upazila, Kurigram) and 4 villages in Islampur upazila, Kishoreganj)
- 2 villages from deep haor or remote char and 2 villages from mainland from each upazila
- 1 village from behind/weak village and 1 village from moderate village from each island or mainland of each upazila
- Where there is no community clinic
- Where is no Blue Star provider

b) Number of Growth Monitoring Provider: 1 provider will be selected from each large village (At least more than 500 households per village) as this provider requires a minimum satisfactory level of revenue/earnings from a satisfactory numbers of customers or clients considering sustainability of providers that in turn sustainability of GMP service

c) The Growth Monitoring Promotor will be self-selected

d) Having strong desire to be small business entrepreneur,

e) Having community acceptance and some sorts of health & nutrition related knowledge and or skills.

4. Timeline and staff needs for completing the pilot [How many months; how often should a review be done before final decisions is made]

**Timeline:** Total seven months from July 2019 to January 2020.

- Finalization of design: July 2019
- Training for Growth Monitoring Promotor: July 2019
- Growth Monitoring Promotors start service provisioning: August 2019 to January 2020

**Staff requirement:** No additional staff is required

**Assessment:** After the end of piloting, an assessment will be conducted to see the effectiveness of this intervention and also evaluate service quality, relevance, efficiency and effectiveness etc.

5. Success factors: - this is a projection of when do we say the pilot has succeeded. [could be economic- eg incomes for LSP, social- acceptance by many community members… or a mix]

- Sufficient income that motivated providers to continue services
- Community accepted them as service providers
- MoH&FW counterparts recognized and provided support
- Standard of services (Knowledge of skills of providers)

6. Suggested replication scaling up model [1 paragraph]

After the end of piloting, an assessment will be conducted to see the effectiveness of this intervention and also evaluate service quality, relevance, efficiency and effectiveness etc. Based on assessment result, program will scale up this intervention in villages where similar approaches can be undertaken. In sampling section, different samples are proposed based on criteria of villages, such as, behind versus moderate, island versus mainland, vulnerability and socioeconomic context. Pilot will explore and guide where we can replicate to see results of different variables of different types of villages.

## Annex 2: GMP Pilot Assessment Data Collection Tool

| SHOUHARDO III |
|---|
| Growth Monitoring Promoter Pilot Assessment |
| Interview Checklist for the Growth Monitoring Promoters |

| |
|---|
| **Introduction:** The interviewer will introduce him/ herself to the participant. Before starting the interview, s/he will explain the context (inability to conduct face-to-face interview due to COVID-19 crisis) behind this remote data collection procedure. If requires the interview date and time can be settled down through an earlier phone call. S/he will narrate the objective of this interview and with the participant's consent, h/she will conduct this interview and collect the information. |
| **Objective:** The objective of this study is to assess the effectiveness of Growth Monitoring Promoter model under SHOUHARDO III area |

| Topic Areas | Question | Responses |
|---|---|---|
| Service Provision | Q1. How many villages have you provided GMP services? | 1) 01 |
| | | 1) 02 |
| | | 3) 03 |
| | | 4) 04 |
| | | 5) 05 or more |
| | Q2. What is the average (head count) number of pregnant women you provided weight monitoring services in a month? | 1) 01-15 |
| | | 2) 16-30 |
| | | 3) 31-45 |
| | | 4) 46-60 |
| | | 5) Above 60 |
| | Q3. What is the average (head count) number of children under 0-59 months you provided GMP services in a month? | 1) 01-15 |
| | | 2) 16-30 |
| | | 3) 31-45 |
| | | 4) 46-60 |
| | | 5) Above 60 |
| Monthly income | Q4. What was your average monthly income from the GMP/weight monitoring services from under 5 children and pregnant women? (In BDT) | 1) 0-200 |
| | | 2) 201-500 |
| | | 3) 501-700 |
| | | 4) 701-1000 |
| | | 5) Above 1000 |
| | Q5. How you spent the service charge earned from GMP services? (Multiple responses applicable) | 1) Spent on family purpose |
| | | 2) Spent on children |

| | | |
|---|---|---|
| | | 3) Spent on personal need |
| | | 4) Saved |
| | | 5) Gave husband or other family members |
| | | 6) Invested in business or other work |
| | | 7) Others |
| | Q6. Do you have any other income sources? | 1) Yes (Proceed to Q6A - Q6B) |
| | | 2) No (Proceed to Q7) |
| | Q6A. If yes, what are the (other) sources for your monthly income? | |
| | Q6B. What's the average monthly income from that source? (In BDT and in kind). | 1) BDT: |
| | | 2) In kind: |
| Horizontal & Vertical Linkages (Health care service providers) | Q7. Name the health care service providers that work in your area? (Examples from the responses) | 1) |
| | | 2) |
| | | 3) |
| | | 4) |
| | | 5) |
| | | 6) Others (Please specify) |
| | Q8. Who are you connected (in terms of functional relationship) with any health care service providers/ facilities from your area? Please name at least one. | 1)<br>2)<br>3) |
| | Q8A. Have you ever received any assistance from any of the health care service providers from your area? | 1) Yes |
| | | 2) No |
| | Q8B. If yes, what type of assistances have you received from them? | |
| | Q9. Are you connected with other growth monitoring promoters? | 1) Yes |
| | | 2) No |
| | Q10. Are you connected with SHOUHARDO III staff? | 1) Yes |
| | | 2) No |
| | Q10A. Have you received enough support from SHOUHARDO III staff? | 1) Yes (Proceed to 10B) |
| | | 2) No (Proceed to 11) |
| | Q10B. If yes, what type of assistances have you received from them? | |
| Motivation | Q11. What's your motivation to work as a Growth Monitoring Promoter?<br>(Multiple responses applicable) | 1) Financial independence |
| | | 2) Being Empowered |
| | | 3) Skill development |
| | | 4) Serving the community |
| | | 5) Work for a better future |
| | | 6) Support my family |

| | | |
|---|---|---|
| | | 7) Community acceptance respect |
| | | 8) Networking with health department and support |
| | | 9) Don't know |
| | Q12. Have you received enough support from your family members while working as a GMP? | 1) Yes (Proceed to Q12A) |
| | | 2) No (Proceed Q13) |
| | Q12A. If Yes, please give one example for your family. | |
| | Q13. Have you received any support from the community members while providing GMP services? | 1) Yes (Proceed to Q13A) |
| | | 2) No (Proceed Q14) |
| | Q13A. If yes, please give one example for the community. | |
| Challenges/ barriers | Q14. Have you ever faced any challenges/ barriers while working as a Growth Monitoring Promoter? | 1) Yes (Proceed to Q13A - Q13C) |
| | | 2) No |
| | Q14A. If yes, what type of challenges have you faced? (Multiple responses applicable) | 1) Difficulties to receive payment |
| | | 2) Financial challenges |
| | | 3) Lack of family support |
| | | 4) Travel/ transport difficulties |
| | | 5) Time management |
| | | 6) Lack of knowledge and skill |
| | | 7) Community's demand for diversified services |
| | | 8) Competition due to other GMP service providers from GoB or other NGOs |
| | | 9) Other (Please Specify) |
| | Q14B. Have you taken any steps to resolve these challenges? | 1) Yes |
| | | 2) No |
| | Q14C. If yes, what are the steps did you take? | |
| Recommendations | Q15. Do you have any suggestions for the program before we train and roll out other GMPs? | 1) Yes (Proceed to Q15A) |
| | | 2) No |
| | Q15A. If yes, please specify two suggestions. | |

| SHOUHARDO III |
|---|
| **Growth Monitoring Promoter Pilot Assessment** |
| **Focus Group Discussion Checklist for Program Participants** |

**Objective:** The objective of this study is to assess the effectiveness of Growth Monitoring Promoter model under SHOUHARDO III area.

Respondents should be the households that have pregnant women/or lactating mothers (having children under 2 years).

| Topic Areas | Question | Responses |
|---|---|---|
| Level of awareness | Q1. Do you know about the services provided by Growth Monitoring Promoter in your area? | 1) Yes |
| | | 2) No |
| | Q2. Have you/ any of your family members received the services? | 1) Yes |
| | | 2) No |
| | Q3. Do you believe that the service is important/ benefitted you or your family members? | 1) Yes (Proceed to Q3A) |
| | | 2) No (Proceed to Q4) |
| | Q3A. If yes, how have you/your family benefitted from such services? | |
| Willingness to pay | Q4. Are you willing to continue paying for the GMP and counseling services you receive from the Growth Monitoring Promoters? | 1) Yes (Proceed to Q4A - Q4B) |
| | | 2) No (Proceed to Q4C) |
| | Q4A. If yes, why? | |
| | Q4B. If yes, what is the average amount that you would like to pay for the services each time you receive it? (in BDT) | 1) BDT 10 |
| | | 2) BDT 15 |
| | | 3) BDT 20 |
| | | 4) Others (Please specify) |
| | Q4C. If no, what are the reasons behind your decision? (Multiple responses applicable) | 1) Financial reasons |
| | | 2) I do not feel like spending for the service (I don't feel that it is a |

| | | |
|---|---|---|
| | | service that adds value at all) |
| | | 3) I have to take the money from other family members (i.e. husband) |
| | | 4) There're free services |
| | | 5) Other (Please specify) |
| Community perception | Q5. Are you/ your family members satisfied with the quality of GMP services (advices, counseling, referral to doctors/ specialists, improvement for growth faltering cases) you received? | 1) Yes (Proceed to Q5A) |
| | | 2) No (Proceed to Q5B) |
| | Q5A. If yes, why are you satisfied most from the service? | |
| | Q5B. If no, what are the reasons behind your opinion? /Why? | |
| | Q6. What changes (other requirements) should be incorporated into the service to improve the quality? (List down the suggestions) | |

| SHOUHARDO III |
|---|
| **Growth Monitoring Promoter Pilot Assessment** |
| **Key Informant Interview (KII) Checklist for Stakeholders** |

**Introduction:** The interviewer will introduce him/ herself to the participant. Before starting the interview, s/he will explain the context (inability to conduct face-to-face interview due to COVID-19 crisis) behind this remote data collection procedure. If requires the interview date and time can be settled down through an earlier phone call. S/he will narrate the objective of this interview and with the participant's consent, h/she will conduct this interview and collect the information.

**Objective:** The objective of this study is to assess the effectiveness of Growth Monitoring Promoter model in SHOUHARDO III area.

**List of stakeholders:** MoH&FW field staff (FWV, FWA, and HA), CFCP, UP Member/UP Female Member, NGO Health Worker etc.

| Topic Areas | Question | Responses |
|---|---|---|
| Personal information | Name: | |
| | Occupational details (Position, Organization): | |
| | Location (Village, Union, Upazila, District): | |
| Perception on Growth Monitoring Promoter | Q1. Are you aware about the services provided by Growth Monitoring Promoter in your area? | |
| | Q2. Do you think that they are adding value in their communities? | 1) Yes (Proceed to Q3)<br>2) No (Proceed to Q2A) |
| | Q2A. Why do you think so? | |
| | Q3. How the services provided by GMPs are adding values to the local health care facilities? | |
| | Q4. What are your suggestion for the Growth Monitoring Promoters to contribute more in the community? | |
| | Q5. What can you/ your organizations/ institute/ company do to improve the capacity of the growth monitoring promoters? | |