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Maternal and Child
Survival Program

MCSP Community Health Contributions Series: Bangladesh

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Background

The US Agency for International Development (USAID)'s flagship Maternal and Child Survival Program (MCSP) operated globally and within 32 countries with the ultimate goal of preventing maternal and child deaths. To support community health structures in countries, MCSP advocated for institutionalizing community health as part of national health systems, strengthening the capacity of community health workers (CHWs), and supporting community infrastructure in partnership with country governments and civil society organizations. This brief is one of an eight-part series developed by MCSP to review and understand the processes of community engagement in MCSP-supported countries and identify how the community health approaches implemented by the project have contributed to changes in health service uptake and behavioral outcomes.



An expectant mother from a remote village in Bangladesh travels to the nearest union health and family welfare center to deliver her baby. In intervention upazilas of the MaMoni HSS project, community action groups established emergency transport systems for maternal and newborn care within their communities. Photo Credit: GMB Akash/ Save the Children

In Bangladesh, MCSP supported the MaMoni Health Systems Strengthening (HSS) project, which was a five-year (2013–2018) associate award under MCSP's predecessor project, the USAID Maternal and Child Health Integrated Program (MCHIP). MaMoni HSS's overall goal was to increase utilization of integrated maternal, newborn, and child health, family planning, and nutrition (MNCH/FP/N) services, through improved service readiness, strengthened national and district health systems, and reduction in barriers to accessing health services. MCSP undertook this review of the MaMoni HSS project to understand the process and outcomes of community engagement in Bangladesh.

Community Health Focused on MNCH/FP/N

To strengthen community health, MaMoni HSS provided support and assistance to the Bangladesh Ministry of Health and Family Welfare (MOHFW) at the national, district, and sub-district levels to increase quality public sector service delivery and significantly streamline its approach to community mobilization. Through strengthening the existing union education, health, and FP standing committees, the project sought to engage communities to mobilize resources and strengthen community response for MNCH/FP/N issues. Community health activities covered four high-intensity project districts (i.e., Habiganj, Lakshmipur, Jhalokathi, and Noakhali).

MaMoni HSS used a multi-pronged strategy to enhance community engagement around MNCH/FP.¹ MCSP's global community health strategy combined community service delivery with community capacity-strengthening and community social and behavior change. In Bangladesh, this strategy was used to reduce barriers and increase demand for and use of MNCH/FP/N services. **Table 1** outlines the activities the project undertook to enhance community engagement. Overall, the project institutionalized community microplanning monthly meetings (cMPMs) and leveraged the involvement of local governments to address barriers to service utilization. Additionally, the project worked with union parishads (union councils) to understand a range of responsibilities, at facility and community levels, as outlined by the Government of Bangladesh.² MaMoni HSS also ensured that union council members were aware of the range of community health-related activities that were within their scope and successfully advocated for union council funds to be allocated to address local health needs. The project also trained and supported community volunteers to facilitate community action groups (CAGs), to promote healthy behaviors and care-seeking within their communities, and to liaise with frontline MOHFW health workers (family welfare assistants [FWAs] and health assistants [Has]) during the cMPMs.

Table 1: Three Pillars of the MaMoni HSS Project's Community Health Approaches

Service Delivery	Capacity Strengthening	Social and Behavior Change
<ul style="list-style-type: none"> • Helped establish local governance and oversight by union councils. • Supported routine and emergency referral. • Strengthened civil registration and vital statistics through improved coordination between the MOHFW and the Ministry of Local Government, Rural Development, and Cooperatives. • Supported community volunteers and health workers to maintain a register for their catchment areas with an updated list of pregnant women, childbirths, emergency referrals, and maternal and newborn deaths. • Provided direct project financial support for various elements of service delivery preparedness. 	<ul style="list-style-type: none"> • Trained and provided follow-up support to build capacity of local government institutions to actively contribute to MNCH/FP/N services. • Recruited, trained, and supported unpaid community volunteers to initiate and lead CAGs within their catchment area (of 250–300 people). • Strengthened outreach workers' knowledge and skills for home visits. • Facilitated bi-monthly union education health and FP standing committee meetings. 	<ul style="list-style-type: none"> • Staged community theater shows to support positive changes in health knowledge and behavior, as well as social norms, related to MNCH/FP/N. • Used mHealth to increase awareness on MNCH/FP/N through messages sent via a mobile phone to pregnant and lactating mothers during pregnancy and the postpartum period.³ • Developed various support materials in conjunction with the social and behavior change activities. • Collaborated with the MOHFW to mobilize community volunteers and field-level health providers to promote community awareness about FP/postpartum FP services and methods.

Achievements

Overall, the community health approaches described here contributed to the project's efforts to identify and reduce barriers to accessing health services and contributed to changes in MNCH/FP/N. These approaches showed that it is possible to mobilize local assets and increase transparency, as well as increase accountability around use of local resources. Engagement of local government in health service delivery in high-intensity project districts and the activation of existing management committees was a major achievement of the project. Local government actors gained knowledge on their roles and responsibilities for service delivery and became important sources of advocacy and resources in project areas.

¹ MaMoni HSS nutrition interventions focused on increasing demand for facility-based nutrition services (i.e., severe acute malnutrition screening and facility-based case management).

² 1) Hold service providers in their union accountable and ensure they are not charging for services; 2) help popularize the clinics and promote service utilization within their union; and 3) mobilize resources to address MNCH/FP/N needs within their communities.

³ Aponjon Pregnancy (Aponjon Shogorbha in Bangla) is a locally branded version of Mobile Alliance for Maternal Action (MAMA) initiative, a global public-private partnership between USAID, Johnson and Johnson, Inc., Baby Center, mHealth Alliance, and the United Nations Foundation. Aponjon delivered health information to pregnant women and new mothers using mobile phone technology. Over the life of the project, a cumulative total of 2,070,014 women subscribed to the project and received messages.

Resource mobilization

In total, the project worked with 211 union councils to support and allocate funds for MNCH/FP/N services in the sub-districts. Union councils collectively mobilized BDT 28,547,505 (approximately USD 335,000) in funds for constructing, repairing, and maintaining facilities; purchasing emergency medicine during stock-outs and small medical and non-medical equipment; repairing roads to enable easier access to facilities, and providing temporary support staff when needed (e.g., staff for crowd control during peak hours, cleaners, etc.). In four out of five districts, 83% of CAGs (or, 20,299 of 24,355 possible groups) collectively set up an emergency transport system for maternal and newborn health care within their communities and set aside approximately BDT 1 million for emergency funds to help women access care when they could not afford it.

Community action groups

MaMoni HSS worked with 22,304 active community volunteers in the project's 23 high-intensity sub-districts, called upazilas. Community volunteers facilitated 958,719 monthly CAG meetings over the life of the project in MaMoni HSS areas to coordinate, implement, and follow up on community action plans and support health education and dialogue. CAGs also collected vital event data to share during cMPMs.

Community microplanning meetings

The project established cMPMs so that community volunteers could interface with FWAs and HAs and provide a link between CAGs and the formal health system. During these meetings, health workers and community volunteers addressed discrepancies in their counts of new eligible couples, pregnancies, births, deaths, and other vital information. The meetings also enabled participants to identify follow-up actions for the health workers and community volunteers. Initially, MaMoni HSS staff facilitated the cMPMs as well as union follow-up meetings, but the FWAs and HAs eventually took on the facilitation and provided their cMPM reports directly to the sub-district health complexes. A total of 18,452 FWAs and HAs served as facilitators and recorders for 85% of the cMPMs in the project areas. The members of the cMPMs were also linked with members of the community support groups and community health care providers at the community clinics to ensure improved coordination and sustainability.

Sustainability

The Government of Bangladesh has made moves to commit to ensuring universal health coverage for its population over the next few decades and has acknowledged MaMoni HSS's unique contribution toward this aim. The MOHFW has taken up the MaMoni HSS model in two divisions of Bangladesh (covering 1,200 unions), where they are now providing targeted advocacy and sensitization meetings on the role local government can play in the health sector. The MOHFW provided forums for union council chairmen—who were champions of this cause under MaMoni HSS—to share their experiences and successes within their sub-districts so that additional unions may learn from their examples. As a result, these government actors will continue to play an ongoing role in strengthening service delivery and monitoring progress in improving the quality of care in their own communities. Moreover, community-based assets (i.e., community volunteers, CAGs, cMPMs, and transport networks for referrals) will continue to function and provide benefits to mothers, newborns, and children in the community.

Improvements in MNCH and FP

Population outcomes and service delivery data indicate that the MaMoni HSS community health approaches contributed to the government's effort to improve MNCH/FP/N services and service utilization in implementation areas. For example, household survey data collected by the project showed that in the four high-intensity districts, **facility deliveries increased by 19% during project implementation, from 25% in 2014 to 40% in 2016.** MaMoni HSS-supported districts also fared better in coverage of facility deliveries when compared with the trends in their respective divisions. For example, project household surveys showed that Noakhali (a MaMoni HSS-supported district in the Chattogram division) experienced a 24% increase in facility deliveries from 2014–2016. Similarly, **the percentage of women that received at least one antenatal care visit from a medically trained provider increased by 31% in MaMoni HSS districts,**

from 51% in 2014 to 82% in 2016. Major contributors to the increase in antenatal care attendance and facility deliveries include the project's significant efforts to strengthen union health and family welfare centers in project areas to provide 24/7 delivery care, as well as project activities to raise awareness at the community level on the importance and availability of health services. Additionally, MaMoni HSS **improved demand for long-acting reversible contraception**. Utilization of postpartum intrauterine contraceptive device more than doubled from pre-intervention numbers from 695 in 2015 to 1,682 in 2017.

Conclusion

The MaMoni HSS Project supported Bangladesh in its journey to self-reliance by effectively engaging local government and mobilizing communities to increase utilization of their resources for health purposes. This approach proved to be an effective method to support local governments in removing barriers to service utilization, generating local resources, and strengthening public health facilities. Additionally, the approach ensured participation of community members at scale and helped institutionalize local problem-solving. It also showed that it is possible to increase transparency and accountability around local resource use. The experience in Bangladesh highlights the critical importance of meaningfully engaging community leaders in interventions to improve health care. Local government can play a vital role for sustainable changes in the union health and family welfare centers, as well as to increase utilization of health services. Moving forward, it will be necessary to focus not only on how local governments can be leveraged to support community service delivery, but also on the role they may play in shifting social norms and helping to create supportive environments for sustainable behavior change within households and in their communities.



Actors in a community theater show engage with the audience to involve them in the experience. Photo credit: MCSP

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