Associate Award Brief—Bangladesh

Selected Health and Demographic Data for Bangladesh	
Maternal mortality ratio*	194
Neonatal mortality rate**	32
Total fertil ty rate**	2.4
4 or more antenatal care visits**	25.5%
Contraceptive prevalence rate**	52.1%
Skilled attendance at birth**	31.7%
Postnatal care (two days)**	29.6%

Sources: *National Inst tute of Population Research and Training (NIPORT), MEASURE Evaluation, and icddr,b. 2012. *Bangladesh Maternal Mortality and Health Care Survey 2010*; ** NIPORT, Mitra and Associates, and ICF International. 2013. *Bangladesh Demographic and Health Survey 2011.*

Major Activities:

***MaMoni*:**

- Over 14,000 unpaid community volunteers were selected from and by the communities and trained to mobilize communities around health issues and jump-start community action groupmeetings.
- In Habiganj and Sylhet districts, 5,056 CAGs in 3,613 villages met routinely to discuss health issues and identify beneficiaries for MNH/FP/N services. In Habiganj, more than 2,100 CAGs have been formed in 2,101 villages. More than 100,000 community members participate in these groups, around half of them female.
- Close to 100% of CAGs arranged transportation for community members during an emergency; more than 85% of CAGs collected funds used for transportation of women and newborns to health services, purchase of medicine, and even for repair of roads to health facilities. Innovative *community microplanning* allowed community members to raise health issues directly with public sector health workers and jointly improve health management information system data.
- Collaboration with local and national government and professional agencies and national and international partners, stakeholders, and donors allowed for advocacy of key MNH/FP issues and leveraging of funds for community health issues. Learning from the MaMoni experience resulted in national health policy reforms as well as initiatives to streamline the national health management information system.
- The Standards-Based Management and Recognition (SBM-R®) approach was introduced in five facilities.
- Community health workers and paramedics were deployed to fill critical staff vacancies or to complement providers in high population areas.
- 25,122 eligible couples received long-acting and permanent methods of contraception, 114,886 pregnant women received antenatal care from skilled providers, 42,524 pregnant women were provided with misoprostol tablets for prevention of postpartum hemorrhage, and 51,576 deliveries were conducted by skilled birth attendants.
- Over 19,000 community- and facility-based health service providers were trained in various MNH/FP interventions and strategies including community-based management of pre-eclampsia/eclampsia, Emergency Triage Assessment and Treatment for newborns, postpartum intrauterine contraceptive device insertion, and community mobilization across the program districts of Sylhet and Habiganj. As part of the MaMoni package of care, 610 outreach workers have been trained in infant and young child feeding.
- Integrated training curricula and materials were developed for community health workers in MNH/FP interventions that are used by the government, NGOs, and private providers in Bangladesh.
- All 77 Union Parishads in the program implementation area have active Education, Health and Family Planning Standing Committees that meet every two months to discuss local health issues, a practice initiated as a result of MaMoni advocacy. Additionally, MaMoni has successfully sensitized Union Parishads to allocate budgets for local MNH/FP/N priorities.
- With project resources and additional matching funds, MaMoni renovated two district-level facilities, two upazila- level facilities, and seven union-level facilities, and increased the number of planned satellite clinics from 484 in 2010 to 597 as of September 2013. CAGs and Union Parishads also contributed by providing support to 13 subdistrict-level health facilities providing 24/7 delivery care and satellite clinics.

MaMoni HSS:

The goal of MaMoni HSS is to improve utilization of integrated maternal, newborn, and child health (MNCH)/FP/N services in seven districts in Bangladesh. The project will achieve this goal by increasing availability and quality of high-impact interventions through strengthening district-level local management and health systems. MaMoni HSS proposes a set of high-impact activities to achieve four intermediate results (IRs):

1. Improve service readiness through critical gap management;
2. Strengthen health systems at district level and below;
3. Promote an enabling environment to strengthen district-level health systems; and
4. Identify and reduce barriers to accessing health services.

MaMoni Program Dates	August 3, 2009–April 30, 2014					
Overall Budget	Redacted					
Geographic Coverage	No. of divisions	1/7	No. of districts	2/64	No. of upazilas (counties)	15
MCHIP In-Country Contacts	Ishtiaq Mannan, Chief of Party					
HQ Managers and Technical Advisors	Koki Agarwal, MCHIP Director; Pat Daly, Senior Director, Health and Nutrition; Joseph De Graft-Johnson, Newborn Health Senior Advisor; Angie Brasington, Community Health and Social Change Advisor; Jennifer Shindeldecker, Program Officer; Jaime Mungia, Senior Program Officer					
Partners	Jhpiego, Save the Children, and national partners icddr,b (International Centre for Diarrhoeal Disease Research, Bangladesh), Shimantik, and Friends In Village Development Bangladesh					
MaMoni Health Systems Strengthening (HSS) Program Dates	September 24, 2013–September 23, 2017					
Overall Budget (ceiling)	Redacted					
Geographic Coverage	No. of divisions	3/7	No. of districts	7/64	No. of upazilas (counties)	49
MCHIP In-Country Contacts	Ishtiaq Mannan, Chief of Party					
HQ Managers and Technical Advisors	Koki Agarwal, MCHIP Director; Pat Daly, Senior Director, Health and Nutrition; Joseph De Graft-Johnson, Newborn Health Senior Advisor; Angie Brasington, Community Health and Social Change Advisor; Jennifer Shindeldecker, Program Officer; Jaime Mungia, Senior Program Officer					
Partners	Jhpiego, SC, John Snow, Inc., Johns Hopkins University/Institute for International Programs, national partners icddr,b, DNet, Bangabandhu Sheik Mujib Medical University, and more than 10 local implementing partners					

Acronyms and Abbreviations

CAG	Community Action Group
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
FP	Family Planning
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GOB	Government of Bangladesh
HMIS	Health Management Information System
HSS	Health Systems Strengthening (MaMoni follow-on project)
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
IR	Intermediate Result
MaMoni	MaMoni Integrated Safe Motherhood, Newborn Care, and Family Planning Project
MaMoni HSS	MaMoni Health Systems Strengthening Project
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn, and Child Health
MNH/FP	Maternal and Newborn Health and Family Planning
MNH/FP/N	Maternal and Newborn Health, Family Planning, and Nutrition
MOH&FW	Ministry of Health and Family Welfare
QA	Quality Assurance
SBM-R®	Standards-Based Management and Recognition
SCANU	Special Care Newborn Unit
UP	Union Parishad

Background

Bangladesh has made great progress in reducing maternal and child mortality in the past decade and is on track to achieve targets for both Millennium Development Goals 4 and 5. In the same period, the country has made significant progress in lowering maternal and child mortality. Since 2001, the maternal mortality ratio has declined 40% from 322 per 100,000 live births to 194 in 2010.1 Between 2007 and 2011, under-five mortality declined from 65 to 53 per 1,000 live births. Skilled attendance at birth nearly doubled between 2004 and 2011, reaching 32%, with much of this due to increased facility deliveries. Notably, the contraceptive prevalence rate reached 61% for all methods and the total fertility rate declined to 2.3.2

However, improvement has not been uniform throughout the country, such as in the case of the Sylhet division (where Sylhet and Habiganj districts are located). It has consistently lagged behind in most health indicators, and, over the past several years, this trend has not changed

[1] Bangladesh Maternal Mortality Survey, 2010.
[2] Bangladesh Demographic and Health Survey (BDHS), 2011.

significantly. For example, the national maternal mortality rate (MMR) declined from 322 per 100,000 live births in 2001 to 194 in 2010. During the same 10 years, MMR declined from 352 to 60 (an 83% decrease) in Khulna division. In the Sylhet division, however, MMR only declined from 471 to 425 (less than a 10% change). The neonatal mortality rate in the Sylhet division was 43% higher in 2007 than the national average (53 deaths per 1,000 live births compared with 37 per 1,000 live births across Bangladesh). Significant inequalities persist. MaMoni and MaMoni HSS focus on historically underserved areas of Bangladesh.

Approach/Activities

OVERALL APPROACH: MAMONI

MaMoni focused on supporting the government of Bangladesh's (GOB's) Ministry of Health and Family Welfare (MOH&FW) Health Population and Nutrition Sector Development Program strategy to reduce maternal and neonatal mortality; the project sought the attainment of Millennium Development Goals 4 and 5 in Bangladesh. MaMoni used a comprehensive service delivery model, designed to demonstrate a sustainable approach to strengthening public sector health care delivery systems, to reduce maternal and neonatal mortality and morbidity. Using a district-wide approach, the delivery strategy linked households with health systems and involved local health care providers and strong community groups to promote and sustain household and community practices.

Major Activities: MaMoni

More than 14,000 unpaid community volunteers were selected from and by the communities and trained to mobilize communities around health issues and jump-start community action group (CAG) meetings.

In Habiganj and Sylhet districts, 5,056 CAGs in 3,613 villages met routinely to discuss health issues and to identify beneficiaries for maternal and newborn health, family planning, and nutrition (MNH/FP/N) services. More than 100,000 community members participate in these groups, around half of them female.

Close to 100% of CAGs arranged transportation for community members during an emergency; more than 85% of CAGs collected funds used for transportation of women and newborns to health services, purchase of medicine, and even for repair of roads to health facilities. Innovative community microplanning allowed community members to raise health issues directly with public sector health workers and to jointly improve health management information system data.

Collaboration with local and national government and professional agencies and national and international partners, stakeholders, and donors allowed for advocacy of key MNH/FP issues and for leveraging of funds for community health issues. Learning from the MaMoni experience resulted in national health policy reforms as well as initiatives to streamline the national health management information system.

The Standards-Based Management and Recognition (SBM-R®) approach was introduced in five facilities.

Community health workers and paramedics were deployed to fill critical staff vacancies or to complement providers in high population areas.

Under MaMoni, 25,122 eligible couples received long-acting and permanent methods of contraception, 114,886 pregnant women received antenatal care from skilled providers, 42,524

pregnant women were provided with misoprostol tablets for prevention of postpartum hemorrhage, and 51,576 deliveries were conducted by skilled birth attendants.

More than 19,000 community- and facility-based health service providers were trained in various MNH/FP interventions and strategies including community-based management of pre-eclampsia/eclampsia, Emergency Triage Assessment and Treatment for newborns, postpartum intrauterine contraceptive device insertion, and community mobilization across the program districts of Sylhet and Habiganj. As part of the MaMoni package of care, 610 outreach workers have been trained in infant and young child feeding. Integrated training curricula and materials were developed for community health workers in MNH/FP interventions that are used by the government, NGOs, and private providers in Bangladesh.

All 77 Union Parishads (UP; local government bodies at the union level) in the program implementation area have active Education, Health and Family Planning Standing Committees that meet every two months to discuss local health issues, a practice initiated as a result of MaMoni advocacy. In addition, MaMoni has successfully sensitized UPs to allocate budgets for local MNH/FP/N priorities.

With project resources and additional matching funds, MaMoni has renovated two district-level facilities, two upazila-, or county-, level facilities, and seven union-level facilities and has increased the number of planned satellite clinics from 484 in 2010 to 597 as of September 2013. CAGs and UPs also contributed by providing support to 13 subdistrict-level health facilities providing 24/7 delivery care and satellite clinics.

Overall approach: MaMoni HSS

The goal of MaMoni HSS is to improve utilization of integrated maternal, newborn, and child health (MNCH)/FP/N services in seven districts in Bangladesh. The project will achieve this goal by increasing availability and quality of high-impact interventions through strengthening district-level local management and health systems. MaMoni HSS proposes a set of high-impact activities to achieve four intermediate results (IRs):

1. Improve service readiness through critical gap management;
2. Strengthen health systems at district level and below;
3. Promote an enabling environment to strengthen district-level health systems; and
4. Identify and reduce barriers to accessing health services.

Results

MaMONI

Project data indicate that MaMoni has achieved significant increases in deliveries with skilled birth attendants, referrals for maternal complications, and postnatal care, as well as modest improvements in utilization of family planning (FP) services. These gains were realized through the active participation of community volunteers, CAGs, and UPs; testing of new implementation models in hard-to-reach areas (e.g., upgrading union health and family welfare centers); and an integrated approach to health systems strengthening that included providing temporary frontline health workers (community health workers, paramedics), renovating facilities, ensuring adequate medicines and supplies for normal delivery, postpartum hemorrhage prevention, and postpartum FP, and strengthening supervision. Microplanning meetings introduced under MaMoni have significantly improved data quality and local-level

planning among the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) workers and the community.

MaMoni's achievements go beyond improved utilization rates. MaMoni is the only project in Bangladesh to have delivered an integrated package of lifesaving interventions for mothers and newborns through the existing health system. Using a district-wide model, MaMoni grafted itself to the health system and supported delivery of services from community level to district hospital.

Perhaps most notable among MaMoni's achievements are the scale to which CAGs functioned in Habiganj and how these groups were formally linked to the health system through the innovation of community microplanning. More than 2,100 CAGs met routinely throughout Habiganj, covering 93% of all villages in the district, to discuss health issues and identify possible beneficiaries for maternal and newborn health, FP, and nutrition (MNH/FP/N) services. Representatives from those groups, in turn, participated in routine union-level microplanning meetings to raise health issues with public sector frontline health workers. This allowed for a previously unseen level of communication between communities and health providers, with the added benefit of streamlining surveillance of communities' health needs (e.g., new pregnancies, eligible couples) for targeted services by community-level health providers who are otherwise unable to visit all households in person. This microplanning process has already been demonstrated to reduce discrepancies in data collected by the DGHS and DGFP and has been used to pinpoint specific weaknesses within the data pathway with respect to data quality.
Another of MaMoni's important achievements has been its ability to leverage additional funding for complementary initiatives. Particularly notable are funds leveraged to upgrade union-level facilities in remote and underserved areas to provide 24/7 safe delivery care services. The result has been dramatic increases in the rate of facility delivery among these catchment populations, in most cases exceeding the GOB's targets for skilled birth attendance. These initiatives have caught the attention of the GOB, which is integrating union-level safe delivery into national programs. Leveraged funds have also been used to procure misoprostol for community-based use. Misoprostol, approved for use by the GOB but not yet distributed at the community level, is a lifesaving drug taken after pregnancy to reduce postpartum hemorrhage—the largest cause of maternal mortality in Bangladesh.

In Habiganj, MaMoni introduced the Standards-Based Management and Recognition (SBM-R®) approach for quality assurance of facility-based services at district-level facilities. Use of SBM-R will expand under the follow-on MaMoni Health Systems Strengthening (HSS) Project within Habiganj and in six other targeted districts. In addition, facility renovation is now an important component within MaMoni HSS.

MaMoni has been a credible and effective actor in policy and program discussions at both national and local levels. Learning from the MaMoni program experience has resulted in valuable input and insight into national health policy reforms, especially regarding newborn health interventions (e.g., chlorhexidine), as well as in initiatives to streamline the national health management information system. The MaMoni team is recognized not only for its program delivery but also for its technical competencies. In 2012, the MaMoni team was asked by the MOH&FW to facilitate the process of developing national standard operating procedures for maternal health and a revision to the national maternal health strategy.

MaMoni has worked effectively with other large-scale health initiatives in Bangladesh to provide services to its beneficiaries. For example, linking with national initiatives (e.g., USAID's Mayer Hashi program) to provide long-acting and permanent methods of contraception, MaMoni CAGs referred nearly one-third of long-acting and permanent method services provided in the district. MaMoni's next phase expands this trend and includes additional collaborations with Systems for Improved Access to Pharmaceuticals and Services and other complementary health initiatives operating in Bangladesh.

MaMoni has also served as an important platform for innovation and learning. Through close collaboration with the Translating Research into Action Project, several studies have been initiated, including use of magnesium sulfate at community level to reduce maternal deaths caused by pre-eclampsia/eclampsia. Another successful effort was a collaboration with a UNICEF-funded initiative to establish SCANUs (Special Care Newborn Units) in district-level hospitals. MaMoni established a SCANU at the upazila level and tested a community outreach referral mechanism targeting accessibility of services for sick newborns in the community.

Although MaMoni HSS only began in September 2013, below are key expected results:

Expected MaMoni HSS Key Results

MAMONI HSS GOAL	▪ Increased proportion of pregnant women who deliver by a medically trained provider and seek care for antenatal care, postnatal care, and emergency obstetric needs ▪ Increased proportion of eligible couples use a contraceptive method
OBJECTIVE	▪ Increased number of districts with enhanced MOH&FW leadership and management ▪ Increased number of districts with key facilities having: 1) functional comprehensive QA system, 2) updated health management information system (HMIS) and 3) updated logistics management information system
IR1: IMPROVE SERVICE READINESS THROUGH CRITICAL GAP MANAGEMENT	▪ Increased percentage of vacant staff positions filled ▪ Increased number of service delivery points ready to provide care on relevant components of integrated MNCH/FP/N package
IR2: STRENGTHEN HEALTH SYSTEMS AT DISTRICT LEVEL AND BELOW	▪ Increased number of districts develop a joint, data-driven MNCH/FP/N district plan and use that for periodic performance review ▪ Increased number of health facilities providing services at optimum standard of quality as a result of comprehensive QA mechanism in place ▪ National HMIS includes all essential indicators pertinent to integrated MNCH/FP/N and provides real-time, district-level service coverage estimates
IR3: PROMOTE AN ENABLING ENVIRONMENT TO STRENGTHEN DISTRICT LEVEL HEALTH SYSTEM	▪ Increased number of high-priority national and district critical policies/strategies/guidelines on MNCH/FP/N are developed/finalized and are in effect
IR4: IDENTIFY AND REDUCE BARRIERS TO ACCESSING HEALTH SERVICES	▪ Increased number of women practicing healthy MNCH/FP/N behaviors (e.g., exclusive breastfeeding, delayed bathing, and birth spacing) ▪ Increased number of communities proactively engaged in local health improvement through Community Action Group and Community Support Group membership, through community microplanning, and through facilitating referral network

Next Steps/Looking Ahead

Over the last five years, MaMoni has successfully addressed MNH/FP/N issues in partnership with the MOH&FW and key stakeholders in Bangladesh. Building on these achievements, the MCHIP consortium has received funding to scale up MaMoni in seven new districts through the follow-on MaMoni HSS Project, which will continue through September 2017. MaMoni HSS will build upon the lessons learned under MaMoni to address the MNCH/FP/N recommendations summarized below:

An integrated and comprehensive approach is key to cost effective intervention: To ensure that lifesaving interventions are available and accessible along the household-to-hospital continuum of care, it is essential that a comprehensive approach is used in the provision of health services. MaMoni strengthened MNH/FP/N services within this framework. Instead of introducing vertical programs, MaMoni sought to create change within the districts through an integrated approach with multifaceted structural, technical, and operational systems. This method of working allowed the interventions to be more cost effective and obtained widespread leverage and support from diverse stakeholders at the community and national levels, ultimately ensuring acceptance and success.

Participation of local governments and community groups provided important leverage opportunities: Local institutions, including elected public representatives, played an important role in bolstering the success of health care services in Sylhet and Habiganj. MaMoni secured widespread local government support and engagement on health and nutrition issues, including funds provided by local government, a key achievement of the project. CAGs were present in 93% of the 2,245 villages in the Habiganj implementation area and have collectively set aside around BDT 1 million for emergency funds. Some of the emergency funds have been used to support health facilities and workers with activities such as repair of tube wells and facility access roads and provision of blood pressure monitors, weight scales, furniture, and privacy curtains.

Partnership is critical to success: Partnership with local NGOs and professional bodies, not only directly through grants but also through collaboration on advocacy and programming, paid back well. In many situations, the long-term experience and expertise of local NGOs lent MaMoni broad acceptance in communities. In national advocacy forums, Bangladeshi professional bodies stepped up to prompt changes that would have been impossible for MaMoni to achieve alone. For the first time, injectable magnesium sulfate is being administered at a union level, chlorhexidine is being applied by government providers both at home and health facilities, neonatal resuscitation using the Helping Babies Breathe protocol is being applied in the home setting by community skilled birth attendants in Habiganj, and a Special Care Newborn Unit (SCANU) is operating at the upazila level in Sylhet. These successes were possible because of champions within the MOH&FW and professional bodies.

Partnership with the GOB has been rewarding. Initially, earning mutual trust was challenging, but trust was reached through dialogue. MaMoni has shown that it is possible to work closely with the GOB as the government and program change and develop through mutual support.

Continuous innovation is critical to maintaining visibility and acceptance: MaMoni has served as a testing ground for state-of-the-art interventions such as misoprostol, SCANU, chlorhexidine, calcium supplementation, injectable magnesium sulfate, infant and young child feeding counseling by government providers, and postpartum iron and folic acid distribution by family welfare assistants in home visits, among numerous examples. In many ways, piloting initiatives and then demonstrating results to advocate for scale-up to the national level provided MaMoni with credibility, visibility, and a leadership role in Bangladesh. Through innovations in interventions and service delivery mechanisms, MaMoni has not only improved

the health system but also changed the MOH&FW's vision and targets for developing the health system.

Another key example of MaMoni's piloting of an intervention was the way the program temporarily filled staff gaps as a method of convincing the MOH&FW to address critical human resource issues, since the ministry does not typically have sufficient resources to fill all positions. MaMoni was able to use gap management as an opportunity to educate the MOH&FW and have them focus on active recruitment for vacancies.

Training and capacity-building needs to be linked to supervision and quality assurance for performance improvement: While a not-insignificant gap in service provider capacity needs to be addressed through trainings, MaMoni found that a comprehensive systems approach includes focusing on supervision and quality assurance to improve provider motivation and retention of skills and increase service utilization. In many areas, additional investment beyond initial planning, including provision of job aids, was required to achieve a high level of performance. Trainings need to be linked with performance and providers require support to achieve a results- and performance-oriented manner of working. MaMoni collaborated with the MOH&FW, Ministry of Local Government, Rural Development and Cooperatives, and communities to keep health care providers, local NGOs, and the government accountable.

Data reporting and use: Using government MIS data within the project, MaMoni realized quickly that these data are not complete for decision-making purposes and that data quality is a critical issue at many levels. The Bangladesh Demographic and Health Survey's division-level estimates do not allow for district-level decision-making. MaMoni piloted the Poil union model, which uses family welfare volunteer registers and community microplanning to determine union-level data estimates on population-based health indicators. This pilot demonstrated that, without investing heavily and by simply making slight adjustments to MIS data, health providers can have an improved ability to make decisions. MaMoni not only provided support to improve the GOB's health management information and data collection systems but also invested in giving providers the skills to use the data for decision-making at all levels.

Demonstration followed by advocacy is critical for health systems reforms: Decision-makers need solid evidence to embrace reform. MaMoni, through continuous engagement, caught the attention of policymakers who then supported MaMoni's issues. Advocacy successes were shaped by MaMoni undertaking demonstration activities at the district, upazila, and union levels and using lessons learned and small-scale accomplishments to advocate for change nationally.