# Taking community mobilization to scale:

## The evolving approach to community mobilization over a decade of USAID-funded programming by Save the Children in Bangladesh

***Submitted to:***
Save the Children, USA
March 2018

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## Acknowledgements

This documentation activity was conceptualized by Antje Becker-Benton (Senior Advisor/Team Leader, Behavior Change and Community Health, Department of Global Health, Save the Children USA) and Imteaz Mannan (Senior Advisor Advocacy and Communication, MaMoni HSS Project, Save the Children Bangladesh). With the generous support of a Guyer Fellowship, I was afforded the opportunity to assist in bringing their vision to fruition by reviewing extensive project documentation and interviewing key players involved in the USAID-funded and Jhpiego-led projects ACCESS Bangladesh, MaMoni ISMNC-FP, and MaMoni HSS, where Save the Children performed as the technical lead. This report would not have been possible without their vision, guidance, and insight. I would also like to acknowledge the host of individuals who gave their time to be interviewed about their experience working within the documented projects. Their candid discussions were invaluable in allowing us to better understand the history of these projects and the decisions that were made over time that led to the models of community mobilization in use today by Save the Children Bangladesh's USAID-funded health projects. Finally, thanks are due to those who read and provided constructive feedback on earlier drafts of the report: Antje Becker-Benton, Imteaz Mannan, Joby George, and Joseph Johnson. Save the Children in Bangladesh acknowledges the funding of the documented projects by the United States Agency for International Development (USAID).

## Acronyms

| | |
|---|---|
| AC | ACCESS Counselor |
| ACCESS | Access to clinical and community maternal, neonatal, and women's health services |
| AHI | Assistant Health Inspector |
| AL | Awami League |
| ANC | Antenatal care |
| BNP | Bangladesh National Party |
| CAC | Community Action Cycle |
| CAG | Community Action Group |
| CCS | Community capacity strengthening |
| CDC | Community Development Committee |
| CG | Community Group |
| CHW | Community health worker |
| CL | Community Leader |
| cMPM | Community Microplanning Meeting |
| CmSS | Community Support System |
| CPR | Contraceptive prevalence rate |
| CSA | Community Sales Agent |
| CSG | Community Support Group |
| CSM | Community Supervisors-Mobilizers |
| DGFP | Directorate General Family Planning |
| DGHS | Directorate General Health Services |
| EMNC | Essential maternal and newborn care |
| ESP | Essential Services Package |
| FIVDB | Friends in Village Development Bangladesh |
| FP | Family planning |
| FPI | Family Planning Inspector |
| FWA | Family Welfare Assistant |
| HA | Health Assistant |
| HPSP | Health and Population Sector Program |
| HPSS | Health and Population Sector Strategy |
| HSS | Health systems strengthening |
| IPC | Interpersonal communication |
| ISMNC-FP | Integrated safe motherhood, newborn care, and family planning |
| MCHIP | Maternal and Child Health Integrated Program |
| MIS | Management information system |
| MMR | Maternal mortality ratio |
| MNCH/FP/N | Maternal and newborn health, family planning, and nutrition |
| MNCSP | Maternal Newborn Care Strengthening Project |
| MNH | Maternal and newborn health |
| MOH&FW | Ministry of Health and Family Welfare |

| | |
|---|---|
| MPV | Multipurpose Health Volunteer |
| NGO | Non-government organization |
| NIPORT | National Institute of Population Research and Training |
| PNC | Postnatal care |
| Projahnmo | Project for Advancing the Health of Newborns and Mothers |
| SACMO | Sub Assistant Community Medical Officer |
| SBCC | Social and Behavior Change Communication |
| SCBD | Save the Children Bangladesh |
| SEARCH | Society for Education, Action, and Research in Community Health |
| SMC | Social Marketing Company |
| SNL | Saving Newborn Lives |
| TFR | Total fertility rate |
| UH&FWC | Union Health and Family Welfare Centers |
| UPPR | Urban Partnerships for Poverty Reduction |
| USAID | United States Agency for International Development |
| VDC | Village Development Committee |

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## Executive summary

Since 2006, Save the Children Bangladesh has been active in addressing community health needs through a series of three large, USAID-funded projects to support maternal and newborn health, family planning, and nutrition. This report examines the evolution and contributions of those projects' approaches to community mobilization at increasing scale. It is our aim that by documenting the projects' experiences, learnings, and decisions that led to this evolution over time, Save the Children staff, donors, and other implementers may have a better understanding of how Save the Children Bangladesh arrived at their current approach to community mobilization, and what might be expected when attempting such work in the future or in other contexts.

Despite the common assumption that community mobilization cannot be implemented at scale, the later iterations of Save the Children Bangladesh's projects highlighted in this report have arguably done so. However, a model that sustains community mobilization at scale in the Bangladesh context has come to look very different than it did when originally conceptualized. Through making certain shifts and compromises and building upon successes, Save the Children Bangladesh has, over the last decade, moved from implementing a boutique project based on an intensive project-led community mobilization model to achieving scale through institutionalizing community mobilization activities within existing government structures—and thereby better ensuring responsiveness of the system to community health needs.

The ACCESS project (2006-2009) used an intensive project-driven approach to community mobilization that used home visitors to provide health education to mothers and established Community Action Groups. These groups followed a prescriptive process known as the Community Action Cycle to identify and address their own community's maternal and newborn health issues. As a community-based project without linked facility-based interventions (as mandated by the donor), ACCESS was successful in increasing knowledge about maternal and newborn health and creating demand for services, but improvements in health services utilization was minimal due to the unavailability of many services—caused by widespread staff vacancies and other service constraints.

In order to scale up and devote focus to ensuring the provision of services, the MaMoni Integrated Safe Motherhood, Newborn Care, and Family Planning project (2009-2013) expanded to include facility-based service improvement, simplified and shortened the Community Action Cycle, and relied increasingly more on Community Volunteers to facilitate Community Action Group meetings rather than project staff. The project introduced community microplanning meetings in order to provide a direct interface between community members and the health system. These regular meetings enabled Community Volunteers to share information from their communities with the government's outreach workers to better ensure accuracy of their registers and to make

action plans to address specific barriers to services in their locality. The project also began engaging local government to mobilize resources for improving public sector facilities.

Building upon the success of the first MaMoni project, the follow-on project MaMoni Health Systems Strengthening (2013-2018) further institutionalized the community microplanning meetings and gave increased attention to leveraging the involvement of local government to address barriers to service utilization. The project reactivated the defunct Union Education Health and Family Planning Standing Committee meetings of Union Parishads and oriented local government officials on their authorized roles and responsibilities as outlined by the Government of Bangladesh. The project ensured Union Parishad members and standing committee members were aware of the range of activities that were within their scope to support and successfully advocated for Union Parishad funds be allocated to address local health needs.

Save the Children Bangladesh's approaches to community mobilization at scale did not evolve over time in isolation according to a strict ideology. Rather, the approaches were necessarily responsive to the shifting priorities of the larger projects inline with the government's evolving priorities for health and changes in government structures. Save the Children began by infusing tremendous project support into establishing an initial heavily-structured model for community mobilization appropriate for the Bangladeshi context under ACCESS, and then subsequently streamlined the approach and sought ways to integrate it into existing systems at a national scale. Unlike when ACCESS was first implemented, community mobilization is now part of the Government of Bangladesh's health strategy, and government structures have been established to facilitate the engagement of community members and local representatives in identifying service gaps, providing facility oversight, and mobilizing local funds to address health and family planning needs within local communities. Save the Children Bangladesh, along with other non-governmental organizations in the country, has made key contributions in identifying unique opportunities for meaningful interfaces between government and communities and working to institutionalize those models of engagement at district and national scales. Save the Children's upcoming project, MaMoni Maternal Newborn Care Strengthening Project (2018-2023) will focus on supporting the existing government structures and removing reliance on parallel, project-driven systems for community mobilization which may not be as sustainable.

# Introduction and methods

## Introduction

Since 2006, Save the Children Bangladesh (SCBD) has been active in addressing community health needs through a series of three large USAID-funded projects to support maternal and newborn health, family planning, and nutrition. Save the Children conceptualizes community health programming as comprising three components [Figure 1 & Table 1]: community service delivery, community capacity strengthening, and community-led social and behavior change communication (SBCC).[1] Over the course of the past decade, the relative emphasis of each of these three components within SCBD's projects has varied. However, community capacity strengthening has consistently played a role—even as SCBD's approach significantly evolved over the years as implementation experience grew, government priorities and structures changed, and donor interests shifted.

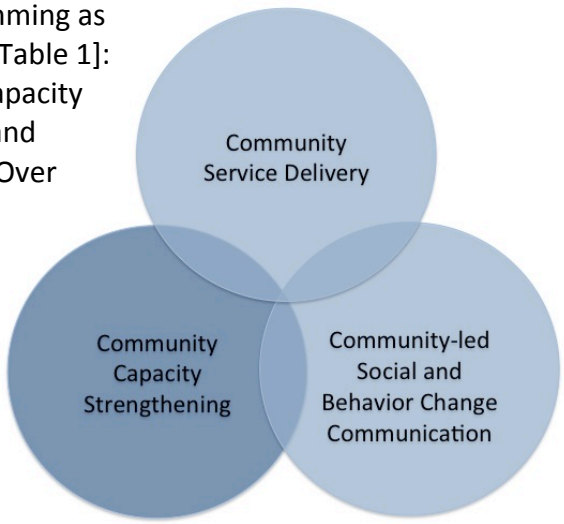



**Figure 1:** Components of Community Health Programming

**Table 1:** Definition of community health programming components

| Component of community health programming | Definition used by Save the Children |
|---|---|
| Community service delivery | The provision of a continuum of health promotion, disease prevention, and curative services by a cadre of community health workers and community groups responsive to community needs and context; this includes concepts of accountability and quality improvements from a community perspective |
| Community capacity strengthening | The process through which communities obtain, strengthen and maintain the capabilities to set and achieve their own development objectives over time[2] |
| Community-led social and behavior change communication | The systematic application of interactive, theory-based, and research-driven processes and strategies to address social and behavioral change at the individual, community, and social levels, including the cross cutting use of strategic communication[1] |

Community capacity strengthening refers to a process through which communities obtain, strengthen and maintain their capabilities to set and achieve their own development objectives over time.[2] Community mobilization is a commonly used approach in many Save the Children projects to help strengthen community capacity to effect improvements in community health.[3] Save the Children's definition of community mobilization refers to a process through which community members, groups, or organizations plan, carry out, and evaluate activities to achieve a common goal—through their own initiative or stimulated by others.[2] Community mobilization can

enable community members to better understand the health issues important in their locality, identify what issues may be inhibiting the use of information or services, engage in collective action to address them, and in so doing ultimately increase demand for and use of services.[4]

This report examines the evolution and contributions of three Save the Children Bangladesh projects' evolving community capacity strengthening/community mobilization activities. Because of these successional USAID-funded projects, Save the Children Bangladesh presents a unique opportunity to explore such an evolution of approaches at increasing scale over an extended period of time. Despite the common assumption that community mobilization cannot be implemented at scale, the later iterations of Save the Children Bangladesh's projects highlighted in this report have arguably done so. However, a model that sustains community mobilization at scale in the Bangladesh context has come to look very different than it did when originally conceptualized. Through making certain shifts and compromises and building upon successes, Save the Children Bangladesh has, over the last decade, moved from implementing a boutique project based on an intensive project-led community mobilization model to achieving scale through institutionalizing community mobilization activities within existing government structures—and thereby better ensuring responsiveness of the system to community health needs.

It is our aim that by documenting the projects' experiences, learnings, and decisions that led to this evolution over time, Save the Children staff, donors, and other implementers may have a better understanding of how Save the Children Bangladesh arrived at their current approach to community mobilization, and what might be expected when attempting such work in the future or in other contexts.

The report's background section begins with an overview of the maternal and neonatal health context in Bangladesh and then provides a brief introduction to the Government of Bangladesh's community health system and local government structures—an understanding of which are important because of subsequent discussions regarding Save the Children Bangladesh's work to link community members with existing government structures for the improvement of health. The background section concludes by highlighting key research studies that formed the initial foundations of Save the Children Bangladesh's maternal and neonatal health projects. The subsequent section outlines the history and key highlights of each of the three projects' approaches to community mobilization. The report concludes with a discussion of the key factors that have emerged over time as important for community mobilization at scale in Bangladesh and recommended ways forward for future programming.

## Methods

This documentation activity was largely conducted in late 2017 and comprised 1) a review of key documents, 2) key informant interviews, and 3) a series of analysis workshop meetings.

The author reviewed key documents regarding Save the Children's community mobilization work globally, as well as project-specific documents concerning three large USAID-funded projects led by Jhpiego and implemented by Save the Children Bangladesh since 2006. These documents included project proposals, monitoring and evaluation plans, quarterly and annual reports, PowerPoint presentations, community mobilization strategy documents, and reports of previous documentation activities, among others (Annex I: Key project documents reviewed).

Based on initial planning meetings and a preliminary review of key documents, the author compiled a list of key informants familiar with the community mobilization work of the targeted projects and developed a list of questions to guide interviews. Those participating in interviews were primarily staff from Save the Children Bangladesh, Save the Children USA, and partner NGOs implementing the projects in Sylhet and Habiganj, Bangladesh (Annex II: List of key informants & Annex III: Key informant questions).

A series of analysis workshops with Antje Becker-Benton (Senior Advisor/Team Leader, Behavior Change and Community Health, Department of Global Health, Save the Children USA) and Imteaz Mannan (Senior Advisor Advocacy and Communication, MaMoni HSS Project, Save the Children Bangladesh) at the Save the Children Bangladesh office in early December 2017 were critical in reaching consensus on the main conclusions and developing a framework for the report.

## Challenges and limitations

The documentation activity was originally planned for Summer 2016. However, due to local security concerns, Save the Children Bangladesh implemented travel restrictions for foreigners moving within the country. The Guyer Fellowship, which funded this activity, was put on hold until late 2017 when the fellow was available to conduct the documentation activity and had freedom to travel within Bangladesh. The author traveled to Sylhet and Habiganj to interview key informants knowledgeable about project activities, but was unable to directly observe community mobilization activities.

The report synthesizes findings of prior documentation activities, reports to funders, internal project documents and opinions expressed by key informants familiar with the projects—it does not attempt a reanalysis of monitoring and evaluation data. Furthermore, it is not intended to be an exhaustive documentation of the community mobilization strategies of each project (such documents are already available); rather it focuses on their evolution over time. As the report touches on over a decade of programming, there is the chance that key informants' recall of earlier events or decisions made in earlier projects could be biased or incomplete.

# Background

## Status of maternal and newborn health in Bangladesh

The 2010 Bangladesh Maternal Mortality and Health Care Survey showed a 40% decline in the maternal mortality ratio (MMR) over the nine years prior—falling from 322/100,000 live births in 2001 to 194/100,000 live births in 2010.[5] By 2010, 27% births were attended by trained providers and 23% were conducted in facilities (10% public, 11% private).[5] Thirty-one percent of maternal deaths were attributed to postpartum hemorrhage and 20% to eclampsia.[5]

The recently released preliminary results of the 2016 Bangladesh Maternal Mortality and Health Care Survey showed an increase in facility-based deliveries from the 2010 figures to a current 47% (14% public, 29% private), however the MMR increased to 196/100,000 live births.[6] Postpartum hemorrhage and eclampsia remain the largest contributors to maternal deaths, and the risk of dying from these complications has remained virtually unchanged since 2010.[6] Save the Children Bangladesh interprets the preliminary findings of stagnating MMR despite an increase in facility-based deliveries as a clear indication that efforts have been successful in increasing service utilization across the country, yet the majority of facilities are not fully ready to provide high quality maternity care.[6]

The 2014 Bangladesh Demographic and Health Survey found that Bangladesh achieved the Millennium Development Goal 4 by reducing their under-5 mortality to 46 deaths per 1,000 live births.[7] Infant mortality is 38 deaths per 1,000 live births and neonatal mortality is 28 per 1,000 live births—meaning neonatal deaths comprise 61% of all under-5 deaths.[7] Neonatal mortality has fallen by 46% over the past two decades in Bangladesh.[7]

According to the 2014 Bangladesh Demographic and Health Survey, key newborn care practices have improved since 2007.[7] Among home births, the use of boiled instruments for cord cutting has increased from 62% to 83%, drying within five minutes of birth has increased from 6% to 67%, and the practice of delaying bathing until after 72 hours has increased from 17% to 34%.[7]

The total fertility rate (TFR) in rural areas is 2.4, while the urban TFR is 2.0 births per woman of reproductive age.[7] The contraceptive prevalence rate (CPR) of any modern method has increased from 47.5 in 2007 to 54.1 in 2014.[7] In the low performing division of Sylhet, the rate has increased from 24.7 in 2007 to 40.9 in 2014.[7] The percentage of last live births in the three years preceding the survey for which women received four or more antenatal care (ANC) visits from any provider increased from 22.0% in 2007 to 31.2% in 2014.[7]

## Government of Bangladesh's primary healthcare system and local government structure

### *Community Clinics*

In the mid 1990s, the Bangladesh government reformed its Ministry of Health and Family Welfare to move from a project-driven approach to sector-wide programming, management, and financing. The Health and Population Sector Strategy (HPSS) was approved in 1997, and the initial implementation plan for the strategy, known as the Health and Population Sector Programme (HPSP), began implementation in 1998. One of the key components of the HPSP was to establish an Essential Services Package (ESP) designed to address the health and family planning needs of the most vulnerable—particularly poor women and children in rural areas.[8]

To facilitate delivery of the Essential Services Package, a system of Community Clinics was established across the country (1 per 6000 population). As the lowest tier health facility within the public sector, Community Clinics were originally designed to provide free-of-charge health education and promotion, treatment of minor ailments, first aid of minor injuries, screening for non-communicable diseases, and referrals to higher-level facilities in the case of emergencies or complications.[8] Each Community Clinic was to be staffed by community-based field workers—a Health Assistant (HA) and a Family Welfare Assistant (FWA) accountable to the Directorate of Health Services and the Directorate of Family Planning respectively (due to the Ministry of Health and Family Welfare's dichotomous structure).

With the acknowledgement that public sector services could not alone meet all the needs of the population, effort was made to build partnerships with communities to ensure participatory support and sustainability of the Community Clinics.[9] The government provided resources for the clinics' construction, staff salaries, equipment, and medicines, but communities were responsible for donating land for the clinics and for establishing Community Groups (CG) to supervise clinic construction, provide operational management, ensure regular maintenance and repairs, and to motivate community members to seek services.[9]

By 2001, 10,723 Community Clinics had been constructed, but only 8,000 had begun functioning.[10] With the change in government in 2001, the Community Clinics closed for several years as priorities shifted.[11] Since 2009, the government has been undertaking a revitalization of the Community Clinic system. A study in 2012 to assess the development and functioning of the clinics found them to be contributing poorly to the Essential Services Package.[8] A large proportion of clinics were closed or poorly maintained, there were severe shortages of supplies, staff had insufficient skills, and communities considered the services to be of low quality.[8]

The Government of Bangladesh is now implementing its fourth sector-wide program (2017-2022), and efforts have been made to increase community engagement through the Community Clinics. In addition to Community Groups that are meant to play

managerial roles, Community Support Groups (CSG) are being established (3 per Community Clinic catchment area) to raise awareness in communities regarding basic health behavior recommendations and the availability of services at the clinic.[12] The Community Support Groups were directly modeled after CARE Bangladesh's Community Support System (CmSS).[13]

***Box 1: CARE Bangladesh's Community Support System (CmSS)[13]***

*In 1999, CARE Bangladesh created the Community Support System (CmSS) to help community members take ownership of their roles in improving maternal and newborn health in poor, rural areas of the country. The CmSS consists of a process to identify local causes of maternal deaths, involve community members in identifying their roles in preventing such deaths, and establish linkages with the health system and local government to address concerns. The CmSS tracks all pregnant women and supports them as needed to ensure safe pregnancies and deliveries.*

Furthermore, the latest sector program also supports the revitalization of union-level facilities known as Union Health and Family Welfare Centers (UH&FWC) that are staffed with providers more highly skilled than those at Community Clinics. These facilities periodically conduct "satellite clinics" where UH&FWC health workers provide services such as immunizations, antenatal and postnatal care, and family planning to remote populations that are unable to access facilities within their communities.

### *Local government structure*

Bangladesh comprises eight major administrative divisions (known as states or provinces in other countries). These divisions are divided further into 64 districts, which are further divided into subdistricts or *upazilas*. In rural areas, subdistricts are further divided into unions—the smallest rural administrative unit. The smallest local government unit is known as the Union *Parishad* (Union Council) [Figure 2], which consists of an elected chairman and twelve elected members—three of which must be women.[14]

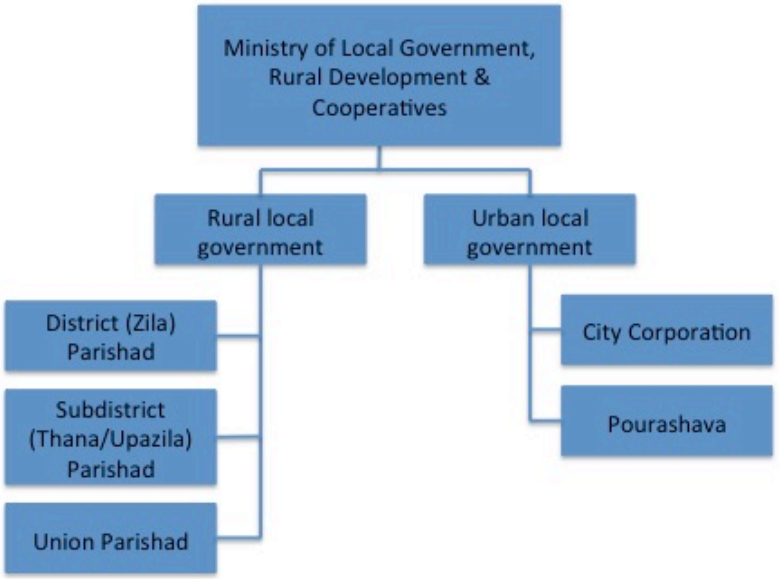



**Figure 2:** Bangladesh Local Government Structure

In addition to the elected board of members, Union Parishads are mandated to have at least 13 standing committees on issues such as health, family planning, education, agriculture, and social welfare. Although standing committees should meet every two months, most of these standing committees across the country are nonfunctioning due to chairmen's and members' lack of awareness or interest about their functions.

## Overview of foundational research informing the highlighted projects

Save the Children Bangladesh's work highlighted in this documentation activity leveraged learnings from a number of precursor research studies on preventing maternal and neonatal mortality. Most directly, the findings and experience from the SEARCH field trial in Gadchiroli, India and the Projahnmo I study in Sylhet, Bangladesh formed the evidence base upon which Save the Children's USAID-funded maternal and newborn health projects, particularly the ACCESS project, were created. The following section gives a brief overview of these two seminal studies.

### *SEARCH field trial (1995-1998)*

From 1995-1998, SEARCH (Society for Education, Action, and Research in Community Health) with funding from The Ford Foundation and The John D and Catherine T MacArthur Foundation conducted a field trial in Gadchiroli, Maharashtra State, India. Covering a population of 81,147, the study catchment area comprised 39 intervention villages and 47 control villages in an extremely underdeveloped district where roads, communications, education, and health services were poor.[15] With health services out of reach, the trial sought to test the hypothesis that a home-based newborn care package that included at-home treatment of neonatal sepsis through injectable antibiotics by community health workers could reduce the neonatal mortality rate by at least 23% over three years.[15] The home-based newborn care and health education provided to mothers and grandmothers was shown to be acceptable and feasible in the

study context, and surpassed expectations by reducing the neonatal mortality rate by 62%.[15] These results inspired the Bill and Melinda Gates Foundation to fund Save the Children's Saving Newborn Lives program and helped to inform the development of the Projahnmo studies in Bangladesh.

### *Projahnmo I Study (2001-2006)*

The Projahnmo Study Group was established by Dr. Abdullah Baqui in 2001 as a partnership among Johns Hopkins University, the Bangladesh Ministry of Health and Family Welfare, Brigham and Women's Hospital, icddr,b, and the Child Health Research Foundation.[16] With funding from USAID and Save the Children's Saving Newborn Lives program through a grant from Bill and Melinda Gates Foundation, Projahnmo (Project for Advancing the Health of Newborns and Mothers) conducted a study in 2001-2006 aiming to replicate SEARCH's findings with a similar delivery model at a larger scale in Bangladesh. Implemented in three subdistricts of Sylhet District with 113,816 study participants across three study arms, the trial tested the hypothesis that both a home-care model and a community-care model for promoting neonatal health in rural Bangladesh would influence key healthcare behaviors and result in a 40% reduction in neonatal mortality.[17] Sylhet Division had the highest mortality rate of the six divisions in Bangladesh at the time, and the study population had poor access to health services.

In the home-care arm, community health workers (CHWs) visited households to provide antenatal care (ANC) and postnatal care (PNC) and treated suspected cases of sepsis with injectable antibiotics. Community Mobilizers hosted community group meetings through which they disseminated birth and newborn care preparedness messages. These meetings were also hosted in the community-care arm of the intervention, but rather than providing in-home care by CHWs, community resource people were identified and trained in the community to encourage attendance at the community group meetings and to encourage MNH care-seeking among community members.[17]

The Projahnmo I Study saw a 33% reduction in neonatal mortality in the home-care arm and a non-significant reduction of 9% in the community-care arm.[17] The authors postulated that the community mobilization activities were not done intensively enough and that the community-care model needed more time to become sufficiently well established in order to see positive results. The significant reduction in neonatal mortality was attributed largely to the successful treatment of sepsis with injectable antibiotics by CHWs in the home. Projahnmo provided the evidence base in Bangladesh that home-based care of newborns has the potential to significantly improve newborn survival and has subsequently formed the foundation for many organizations' program strategies aiming to address newborn health in the country.

## History and evolution of community mobilization approaches

On the heels of the Projahnmo I Study, Save the Children Bangladesh began implementing a series of large USAID-funded community health projects at increasing scale to improve maternal and newborn care behaviors and survival. The three projects primarily highlighted in this report include the ACCESS/Bangladesh Safe Motherhood and Newborn Care Project (2006-2009), the MaMoni Integrated Safe Motherhood, Newborn Care and Family Planning Project (2009-2013), and the MaMoni Health Systems Strengthening Project (2014-2017). The following section provides a historical overview of the projects with key highlights of their evolving approaches to community mobilization.

## ACCESS/Bangladesh Safe Motherhood and Newborn Care Project (2006-2009)

**ACCESS Project Objectives:**

1. Increase knowledge, skills, and practices of healthy, and newborn behaviors in the home
2. Increase appropriate and timely utilization of home- and facility-based essential MNH services
3. Improve key systems for effective service delivery, community mobilization, and advocacy

### *Scaling up Projahnmo*

The ACCESS Program was a global program sponsored by USAID aimed at reducing maternal and newborn deaths and improving the health of mothers and newborns. The ACCESS Program was awarded to jhpiego, while Save the Children served as the lead implementing organization in Bangladesh along with Shimantik and Friends in Village Development Bangladesh (FIVDB) as local implementation partners. The $6 million ACCESS/Bangladesh project was conceived as an attempt to take the Projahnmo model to a larger scale within a programmatic context. The project reached a population of 1.5 million in five subdistricts of Sylhet District—the conservative district where Projahnmo had tested their care models.

Although USAID was interested to see if the Projahnmo model would translate into programmatic successes outside of the controlled research environment, only a few consultations were held with members of the Projahnmo team, and ACCESS was largely planned before the final results of the Projahnmo I Study were available. The final analyses led the study authors to conclude that the provision of injectable antibiotics in the home by Projahnmo's CHWs was largely responsible for the significant reduction in neonatal mortality in the home-care arm, and that the community-care arm was not effective at reducing newborn deaths [personal communication via key informant interview]. However, the government cadre of CHWs—Female Welfare Assistants (FWA) and Health Assistants (HA)—are not authorized to provide injectable antibiotics like the

study-trained CHWs had been, and therefore the Projahnmo model in its full form would not be directly scalable without creating parallel delivery systems.

Rather than addressing community service delivery, ACCESS focused primarily on demand creation for maternal and newborn health services through community-based social and behavior change communication and community capacity strengthening through community mobilization activities. ACCESS built upon the Projahnmo model of home visitors (though removing the home-based treatment of neonatal sepsis and instead encouraging health facility referrals, per donor decision) and significantly intensified the approach to community mobilization by employing the Save the Children's model known as the Community Action Cycle (CAC) [Figure 3] that had been previously tested in other countries.[1] Projahnmo's community-care model had proven ineffective, so ACCESS took its direction for community mobilization from the evidence provided by the WARMI Project in Bolivia and the Makwanpur Study in Nepal--which had both indicated that intensive community mobilization through facilitating community groups to conduct Community Action Cycles could lead to reductions in maternal and neonatal mortality.[18]

**Figure 3:** Community Action Cycle

***Box 2: The Community Action Cycle in Bolivia and Nepal: Successes in improving maternal and newborn health***

***The WARMI Project***

*The WARMI Project was implemented by Save the Children in Bolivia from 1990 to 1993 within 50 rural, isolated communities of Inquisivi Province with limited access to health services. The project sought to reduce maternal and perinatal mortality by working at the community level. Through enacting Community Action Cycles and thereby facilitating community members to implement their own strategies to address mortality, the project was successful in reducing perinatal and newborn mortality by 67%. Knowledge and practices regarding prenatal care, breastfeeding, immunization, newborn care, and family planning also improved.*[18]

***The Makwanpur Study***

*The Makwanpur Study was a cluster randomized controlled trial conducted by the NGO MIRA in the poor, rural district of Makwanpur, Nepal from 2001-2003. The 30-month trial tested whether Community Action Cycles facilitated by women facilitators within Village Development Committees (VDC)—each covering a population of 7500—could reduce neonatal and maternal mortality and improve newborn care practices when compared to control areas. The trial showed a 30% reduction in neonatal mortality and a reduction in the maternal mortality ratio from 341/100,000 live births in the 12 control VDCs to 69/100,000 live births in the 12 intervention VDCs.*[18] *Although quantitative measures were not used to assess changes in community capacity, qualitative research sought to understand how the community mobilization work stimulated change. The women's groups learned about maternal and newborn health topics, established health funds for mothers and children, facilitated emergency transport, produced and sold clean delivery kits, and improved local health facilities by ensuring privacy curtains and necessary furniture, among other activities.*[19] *Two years after the close of the trial, 95% of the women's groups were still meeting regularly.*[18]

### *Project's key community components*

The ACCESS project was primarily a community-based activity with two main components, the first being home visitation provided by ACCESS Counselors (AC). These young female workers covered a catchment area of 5,000-7,000 population and counseled pregnant and recently delivered women and their family members and birth attendants on newborn health and hygiene. A total of four home visits were conducted per household: twice during pregnancy, once within the first 24 hours of birth, and once from five to seven days after delivery.

The second main component of ACCESS was community mobilization using the Community Action Cycle (CAC) approach. The specific community mobilization objectives were as follows:[20]

**Objective 1:** Empower pregnant women and married women of reproductive age in particular and the community in general to make informed decisions regarding maternal and neonatal health care

**Objective 2:** Help change social norms that result in or are related to harmful practices

**Objective 3:** Strengthen the social-support networks/systems for pregnant women

**Objective 4:** Increase collective efficacy to deal with obstetric emergencies

**Objective 5:** Strengthen and/or develop community-based referral systems to increase the use of trained professionals/health workers and/or health facilities for antenatal and postnatal care and safe delivery.

Strategy documents stressed that the community mobilization component's role was to strengthen the community's capacity to collectively analyze, plan, implement, and evaluate their own actions to improve maternal and newborn health. However, key informant interviews with program staff suggested that inclusion of the CAC was seen from the outset of the project to be necessary primarily in order for the project to gain access and acceptance in the community for their activities. Newborn care practices prevalent in Sylhet at the time of the project differed substantially from recommended best practices, and even from practices in other regions of the country. There was concern that households in the conservative communities within Sylhet would not be readily accepting of the project's health behavior recommendations that were markedly different than their current practices.

For instance, the recommendation given by ACCESS Counselors that babies not be bathed for the first 72 hours of life to prevent hypothermia had religious implications for some families, since newborn babies are considered ritually unclean/impure until after their first bath. ACCESS also encouraged women to go to ANC checkups, receive tetanus toxoid vaccinations from satellite clinics, and take newborn babies immediately for postnatal checkups—all of which required mobility of women outside the home. Recommendations like these required more than just behavior change of individuals within households—it was necessary to build community buy-in for such practices. Furthermore, counseling regarding maternal and newborn health issues was considered a matter for women only, pregnancy and childbirth were not to be discussed in public, and direct communication between unrelated males and females was discouraged. The CAC was therefore seen as a way to break the ice by directly engaging males on the topic of maternal and newborn health and to facilitate acceptance of the recommended care behaviors within the community by helping to create environments where changed behaviors could be sustained by supportive social norms.

*Intensively structured Community Action Cycle for community mobilization*

Under ACCESS, the Community Action Cycle (CAC) was implemented at the village level. Female Community Supervisors-Mobilizers (CSM) and male Community Mobilizers (CM), hired as project staff and trained by local partner NGOs, facilitated the Community Action Cycle within each village prioritized for community mobilization activities. Community Supervisors-Mobilizers and Community Mobilizers were assigned to villages where they took responsibility to meet with gatekeepers (e.g. religious leaders, social elites, school teachers, etc.) to obtain permission to work within the community. They then hosted an orientation meeting within each village to which all community members were invited. During the orientation meeting, CSMs and CMs explained the purpose of the ACCESS project, discussed the status of maternal and newborn health in the region, and explained how the Community Action Cycle would be facilitated within their community.

Married women of reproductive age deemed most vulnerable to maternal and newborn health issues, along with their husbands and mothers-in-law, were prioritized for invitation to participate in Community Action Groups (CAG). Where existing community groups were active (e.g. microcredit groups, etc.), CSMs and CMs first determined whether those groups would be interested in carrying out the Community Action Cycle activities. If not, new groups were established. Due to social conservatism, separate groups were established for men and women. Community Supervisors-Mobilizers (female) had the dual role of facilitating the Community Action Cycle activities of female groups and supervising the ACCESS Counselors who provided home visits to pregnant and recently delivered women. Community Mobilizers (male) took responsibility for facilitating the activities of male groups. Many families in the district received remittances from abroad, which freed some male heads of households from daily work. A key informant suggested this might have played a role in allowing them to participate in community group meetings.

These Community Action Groups followed a prescriptive 11-12 month process to complete one Community Action Cycle, heavily guided by the CMs and CSMs at every step. Each meeting had a specific name and list of objectives to accomplish, along with associated tools such as charts, information cards, and body mapping materials to guide meeting activities [Table 2]. After the first cycle had been completed, Community Resource People (CRP) who emerged as natural leaders within the groups would start to take more of a supportive role in helping to facilitate the CAGs.

**Table 2:** Key Meetings of the Community Action Groups[20]

| CAC Phase | Meeting name | Meeting objectives |
|---|---|---|
| Organize the Community for Action | Community orientation meeting | ▪ Orient community members on the project, goal & objectives of CM process<br>▪ Initial selection of focal CRPs |

| CAC Phase | Meeting name | Meeting objectives |
|---|---|---|
| | Core group formation individual consultations and meeting | ▪ Discussion of core group members' roles and responsibilities, CAC process etc.<br>▪ Final selection of core group members<br>▪ Select CRP as a facilitator of the group |
| Explore the Health Issues and Set Priorities | Problem identification meeting: Pregnancy & delivery period | ▪ Identify the problems during pregnancy and delivery |
| | Problem identification meeting: Post natal & Newborn | ▪ Identify the problems during post natal period and newborn |
| | Priority setting meeting | ▪ Setting the priorities of problem |
| Plan Together | Planning meeting with core groups and other community resource people | ▪ Develop a community action plan<br>▪ Organize Community Action Group (CAG) with Core group and other community resource people |
| Act Together | Planning meeting for community capacity strengthening | ▪ To develop community capacity strengthening plan |
| | Monitoring planning meeting | ▪ Develop community progress monitoring plan |
| | Monitoring findings sharing meeting | ▪ Share monitoring team's findings with CAG and other community people |
| Evaluate Together | Evaluation meeting | ▪ Evaluate community progress according to action plan<br>▪ Plan for next cycle based on evaluation findings |

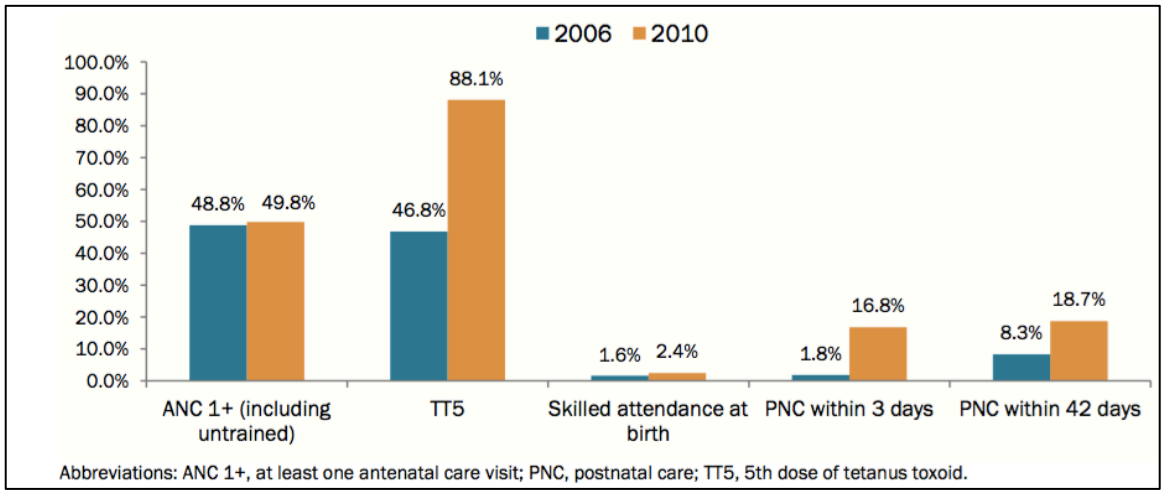
### *Key results*

Monitoring and evaluation of the community mobilization component of ACCESS focused rather narrowly on process/output indicators of how many groups were formed and meeting regularly. At the end of the project, 55.3% of intervention villages had a CAG, 69.1% of those CAGs had met within the last two months, 66.7% of CAGs had action plans to advocate for improved essential maternal and newborn care (EMNC) services, 42.8% had implemented at least two action plans within six months of developing them, and 39.4% of CAGs had at least one representative from the nearest health facility as a member.[21] Many groups took their own initiative to create emergency funds and develop emergency referral transport systems to support their community members who were unable to afford services in times of great need. Monitoring data showed that 56.9% of CAGs established emergency transport systems and 43.4% of CAGs developed emergency finance systems.[21]

Although the midline assessment team and project staff discuss qualitatively their impressions that CAGs were positively influencing social norms and catalyzing change within communities, achievements towards the stated objectives of the community mobilization component were unable to be measured. This was because latent constructs such as empowerment, collective efficacy, social norms, and social support were not assessed by the project. USAID had invested heavily in robust research under Projahnmo, and was more interested in directing ACCESS funds to implementation rather than allotting budget for operations research [per key informant interview]. Doing so could have allowed for the testing and validation of measures for the local context to enable assessment of important outcome level indicators for project learning.

Ultimately, key informants relayed how ACCESS was successful in increasing knowledge about MNH and creating demand for MNH services, but improvements in health services utilization was minimal [Figure 4] due to the unavailability of many services—caused by widespread staff vacancies and other service constraints in the public sector.[22] For instance, the percentage of women in the project area who could not list any danger signs during pregnancy when asked decreased from 3.0% in 2007 to just 0.2% in 2010, those unable to identify delivery danger signs decreased from 6.7% to 0.7%, and those unable to list any postpartum danger signs decreased from 3.5% to 0.6% at endline.[23,24] However, skilled birth attendance increased only slightly from 1.6% in 2006 to 2.4% by 2010, and having one or more ANC visits rose only to 49.8% in 2010 compared to 48.8% in 2006.[22] This supported the shift in focus to including service delivery improvement under subsequent projects.

**Figure 4:** Health indicators in 5 Sylhet Upazilas covered by ACCESS[22]




### *Key learnings and lessons taken forward*

ACCESS's model was heavily project-driven and needed revision before increasing in scale. An external assessment team at project midline made recommendations on how to simplify ACCESS's approach.[25] The heavily structured CAC utilized bulky English terminology such as "Orientation Meeting," "Community Resource Person," etc. and comprised complex meetings and activities that relied on the use of printed cards, posters, maps, and other tools that appeared foreign to the largely illiterate group members. Although Community Resource Persons were identified within groups to sustain activities, they were not well empowered to maintain the complex CAC system of meetings and use of tools without strong support from project staff. Even field level staff hired by the project found the CAC too process-heavy and intricate and felt that community members struggled to understand the CAC in a conceptual way. A member

of the midline assessment team shared his perception that the overly prescriptive CAC process at times may have inhibited community creativity by directing focus too narrowly on the prescribed meetings and required registers. The midline assessment team recommended the removal of many of the CAC tools used during meetings, a streamlining of monitoring data required from the CAGs, and that the CAC be shortened to a 7-9 month process rather than the original 10-12 months.[25]

## MaMoni Integrated Safe Motherhood, Newborn Care and Family Planning Project (2009-2013)

**MaMoni ISMNC-FP Project Objectives:**

1. Increase knowledge, skills and practices of healthy maternal and neonatal behaviors in the home
2. Increase appropriate and timely utilization of home and facility-based essential MNH and FP services
3. Increase acceptance of FP methods and advance understanding of FP as a preventive health intervention for mothers and newborns
4. Improve key systems for effective service delivery, community mobilization and advocacy
5. Mobilize community action, support and demand for the practice of healthy MNH behaviors
6. Increase key stakeholder leadership, commitment and action for these MNH approaches

### *Transition from ACCESS to MaMoni ISMNC-FP*

MaMoni Integrated Safe Motherhood, Newborn Care, and Family Planning Project (MaMoni ISMNC-FP) was an associate award supported by USAID in Bangladesh through the Maternal and Child Health Integrated Program (MCHIP) and implemented by Save the Children and two local non-governmental organizations: Shimantik and Friends in Village Development Bangladesh (FIVDB). The $13 million project extended ACCESS activities for a period of time in five subdistricts of Sylhet District, but expanded coverage under a new model to eight subdistricts in Habiganj District. Reaching a population of 3.5 million, the catchment area included a flood-prone *haor* area, urban slums in the Habiganj municipality, and tea estate communities where low-wage laborers live in settlements on the estates for which they work. Habiganj was an extremely deprived area with dilapidated public health facilities, little to no services available, and no functioning private health sector.

With ACCESS having shown that increasing demand for MNH services alone would not be sufficient for improving utilization, the follow-on project used a more integrated community health approach by directing focus towards supporting public sector service delivery. Rather than investing in a parallel system of home visitors as ACCESS had done,

MaMoni ISMNC-FP relied on existing government cadres of frontline health workers (Female Welfare Assistants) to provide health education and promotion and assisted in temporarily filling critical vacancies for those posts. Furthermore, women had routinely taken ACCESS Counselors aside to discreetly request family planning methods during home visits, and thus family planning was formally incorporated into MaMoni ISMNC-FP programming to address this unmet need. The project also included the addition of handwashing and infant and young child feeding recommendations from 2012 onwards.

### *Project's key community components*

Community mobilization was much simplified under MaMoni ISMNC-FP, aiming primarily to support referrals for government MNH and FP services and to collect community data of vital events to share with frontline outreach workers (Female Welfare Assistants and Health Assistants) in support of the Ministry of Health and Family Welfare's (MOH&FW) management information system (MIS). Although the approach was modified, the objectives of the community mobilization work (according to strategy documents) remained the same as in ACCESS—but with the addition of an objective regarding family planning:[26]

> **Objective 6:** Increase the use of family planning by developing community-based referral systems and systems to ensure easy access and supply of family planning services close to the home.

#### *Streamlined Community Action Cycle*

Under MaMoni ISMNC-FP, the community mobilization approach was simplified from ACCESS in a number of ways. Community Volunteers (CV), selected by Union Parishads, established and facilitated Community Action Groups (CAG) in their own communities from the outset with more limited facilitation from project staff. Union Parishads selected one Community Volunteer per 300 population, which created manageable catchment areas and provided them recognized authority as organizers. Community members from the catchment areas of three Community Volunteers (total 900 population) formed one Community Action Group. Community Action Groups followed a simplified version of the Community Action Cycle over a 6-month period, with reduced reliance on complex tools and registers. Community Volunteers were trained to promote key MNH behaviors among their constituents, and had a 12-hour workload per month.

***Box 3: List of meetings within condensed 6-month Community Action Cycle (CAC)***

1. *Community Orientation*
2. *MNH Problem Identification & Prioritization*
3. *FP and Service Facility Related Issue Identification & Prioritization*
4. *Action Planning and CAG Formation*
5. *Sharing of Monitoring Findings*
6. *Evaluation*

*Adapting the community mobilization approach for varied geographical areas*

Within Habiganj, MaMoni ISMNC-FP was implemented across three geographical areas: 1) rural areas, 2) within tea estates, and 3) urban and semi-urban areas. The main Community Action Cycle model for community mobilization was implemented in the rural areas; however, special modifications were made for those populations residing within tea estates and those within municipalities.[27]

The owners of tea estates were wary of community mobilization work because of the potential they saw for it to lead to uprisings among laborers. Because of this, the project was unable to implement the CAC within tea estate areas. Instead, more emphasis was placed on providing social and behavior change communication through channels such as community theater and film shows.

At the time MaMoni ISMNC-FP was being implemented, Habiganj Sadar Municipality was included in the United Nations Development Program's Urban Partnerships for Poverty Reduction (UPPR) project area. The UPPR project supported community mobilization work through the establishment of Community Development Committees (CDC) facilitated by Community Leaders (CL). These committees developed their own Community Action Plans to identify and address their community's needs in regards to improving living conditions and reducing poverty.[28] MaMoni ISMNC-FP leveraged these existing Community Development Committees within the municipality and considered them as Community Action Groups (CAG) analogous to those established in rural MaMoni areas. MaMoni provided supplemental training for the Community Leaders to orient them to the project's objectives and build their capacity to discuss MNH and family planning issues within their communities. Thus, in addition to the work CDCs were doing to address poverty reduction, they became active in addressing MNH and family planning issues with the support of MaMoni.

In the remaining municipalities within Habiganj, there were wide variations in population, density, and local service structures. Accordingly, MaMoni ISMNC-FP did not implement the structured Community Action Cycle approach in these areas. Rather, Community Volunteers were selected and trained to participate in Community Microplanning Meetings (cMPM) [described below] and were encouraged to assist in referring mothers and newborns to service facilities.

*New approaches for community mobilization*

Innovations for community mobilization were introduced in MaMoni ISMNC-FP, to better facilitate linkages among Community Action Groups and the health system. Community Volunteers collected vital data from their constituents during Community Action Group meetings, which they then shared during Community Microplanning Meetings (cMPM) held monthly with the frontline outreach workers from the Directorate General Health Services (DGHS) and Directorate General Family Planning (DGFP). These meetings, adapted from the World Health Organization's Reach Every District approach,[29] provided forums during which government Female Welfare Assistants (FWA), Health Assistants (HA), and Community Volunteers could address discrepancies in their counts of new marriages, pregnancies, births, deaths, and other information. Because of the Ministry of Health and Family Welfare's dichotomous system of separate health and family planning directorates, two sets of data are routinely collected. With a mandate to serve three days each week in the Community Clinic and three days conducting outreach in households, FWAs (DGFP-supported) and HAs (DGHS-supported) are chronically overburdened and often are unable to sufficiently cover their catchment area each month to maintain complete registers of community data—resulting in counts that are highly discrepant between DGHS and DGFP. As an illustration, in Habiganj from January to June 2012, DGHS reported 49,016 pregnant women and DGFP reported 38,396—a substantial difference of 10,620 women.[22]

***Box 4: Purpose of Community Microplanning Meetings***

1. *Share MNH/FP information and update registers*
2. *Update list of pregnant and high-risk mothers*
3. *Update unit map to facilitate service delivery*
4. *Prepare monthly action plan for service delivery*
5. *Identify problems and plan for solutions*

In addition to synchronizing data, the Community Volunteers along with FWAs and HAs identified problems raised by community members over the past month and jointly prepared monthly action plans for service delivery to address gaps. These action plans targeted specific individuals for follow-up—for instance, if a Community Volunteer identified a woman in his/her catchment area exhibiting pregnancy danger signs who was unable to access services, then a plan was made for specific follow-up with that individual to address her needs. Furthermore, FWAs and HAs shared a "message of the month" with the Community Volunteers during each Community Microplanning Meeting, which the Community Volunteers then promoted during their subsequent Community Action Group meeting. Union Follow-up Meetings then provided forums where all the FWAs and HAs in a Union exchanged information gleaned from their respective Community Microplanning Meetings in the presence of their union level supervisors (e.g. Assistant Health Inspector (AHI) and Family Planning Inspector (FPI)).

They developed union level action plans that addressed needs of the outreach workers and issues concerning union level facilities.

Another innovation in community mobilization within MaMoni ISMNC-FP was the engagement of local government (Union Parishad)—a body that had previously been little involved with MNH and family planning issues. MaMoni helped activate the Union Parishad Education Health and Family Planning Standing Committee, which had a government mandate to meet every two months to discuss local health issues but in most unions did not do so. As members of the Union Parishad Education Health and Family Planning Standing Committee, the Assistant Health Inspector, Family Planning Inspector, and the union level service provider Sub Assistant Community Medical Officer (SACMO) were able to raise concerns during meetings that had not been successfully addressed through cMPM. Community Volunteers advocated with the local government to allocate funding in response to needs identified during Community Action Group discussions, and decisions made at the union level were shared upwards with decision-makers at the subdistrict level. Union Parishads were also engaged to provide oversight for health facility and health worker performance to help ensure community members had increased access to services.

### *Key results*

By November 2013, 93% of MaMoni villages in Habiganj had established Community Action Groups (CAGs).[30] Habiganj was less conservative than Sylhet, which allowed men and women to participate together directly in community group meetings. However, since fewer families rely on remittances from abroad in Habiganj as compared to Sylhet, the project found participation by men to be greatly reduced—presumably because a higher percentage of men in Habiganj were required to work during the day and therefore unavailable to participate in community group meetings [personal communication from key informant]. One hundred percent of CAGs had at least one member who was a health worker, 98% of CAGs had a Union Parishad member participating, 100% of CAGs had established emergency transport systems, and 89% had established emergency funds. Collectively, CAGs had set aside roughly BDT 1 million for emergency funds.[22] In addition to helping women access care when they could not afford it, some of these monies were used to support local health facilities by repairing tube wells, facility access roads, providing blood pressure monitors, weight scales, furniture, and privacy curtains.[22]

MaMoni ISMNC-FP began phasing out implementation in Sylhet District in September 2011 in order to focus implementing the new project model in Habiganj District. This gave an opportunity over the life of MaMoni ISMNC-FP to observe how activities faired once project support was removed. As of July 2013, 54% of Community Action Groups that had been formed in Sylhet District were continuing to function with minimal support.[30]

Community Microplanning Meetings (cMPM) were a standout success of the MaMoni ISMNC-FP project and experienced rapid uptake and high coverage rates. Community microplanning was introduced in each of the 396 family planning units in Habiganj District and 257 units of Sylhet Districts, and meetings occurred regularly in 79% of the project areas in 2011, 96% by 2012, and 99% by 2013.[22] Between June 2011 and April 2013, the National Institute of Population Research and Training (NIPORT) conducted operations research in three subdistricts within the project area and saw improvements in consistency of data reporting between DGHS (registers kept by HAs) and DGFP (registers kept by FWAs) regarding new pregnancies and birth reporting (although improvements were not seen in reporting of newly-wed couples or death reporting). The study indicated that service coverage for maternal care increased as a result of cMPM, particularly ANC (66% increase in Muriauk Union, 34% increase in Kurshi Union, no improvement in Umarpur Union).[22]

As a result of MaMoni's efforts to orient Union Parishads about their roles and responsibilities regarding community health, 77 Union Parishads activated their Education, Health, and Family Planning Standing Committees and were meeting every two months by 2013.[22] This was up from 56 Union Parishads in the first quarter of 2012. By December 2012, 90% of Union Parishads in MaMoni project areas had allocated funds towards MNH/FP efforts.[30] Between July 2012 and March 2013, Union Parishads contributed BDT 81,406 to support Family Welfare Centers (Union-level health facilities), and BDT 170,834 to support Community Clinics.[30] Furthermore, Union Parishads began issuing death certificates for newborns as a result of MaMoni advocating for better documentation of newborn deaths.[22] Encouragingly, some Community Volunteers who were proactive and highly engaged were elected as Members to their Union Parishads during subsequent elections. Since they were well versed on the MNH issues facing their communities, they were able to greatly contribute to MNH support efforts during their service on the Union Parishad.

MaMoni's reliance on the government cadre of community health workers (FWAs) to provide home-based counseling to pregnant and recently delivered women proved challenging—likely due in part to the workers' large catchment areas and mandate to spend three days per week at the Community Clinic.[22] Data from the project's midline assessment in 2012 showed that only 39.7% of mothers had contact with an FWA during pregnancy, and only 6.9% received information on danger signs.[22] According to the project's final report,[22] MaMoni endeavored to address this identified gap by piloting

> *the use of alternative channels of communication (billboards, signboards, film shows for tea gardens, video shows in media-dark areas, cable providers for urban areas) to promote healthy behaviors in communities, but a focused assessment of the changes in knowledge, attitudes, and practices specific to these communication interventions was not completed*. (pg. 13)

### *Key learnings and lessons taken forward*

By shortening and simplifying the Community Action Cycle and making it less prescriptive, the project team felt they were afforded the flexibility to adapt MaMoni's community mobilization approach to more appropriately respond the needs of the varied communities covered in the project's catchment areas. Rather than using a one-size-fits-all approach, the community mobilization work necessarily differed among the rural areas, urban and suburban areas, and within populations residing on tea estates. Furthermore, the process of Community Microplanning was quickly taken up, and the more targeted goal of collecting specific information from community members and liaising with the frontline government workers during monthly meetings strengthened Community Volunteers' and Community Action Groups' capacities to make effectual linkages with the health system. Additionally, anecdotal evidence of the promise of engaging with the local government structure to support maternal and newborn health emerged during MaMoni, and so the follow-on project was planned to more heavily invest in such an approach.

Key informants described how severely destitute the communities within the MaMoni project area were—many with no health services available or government facilities that were extremely dilapidated and the absence of a private sector. The team quickly saw that any small increase in the availability of basic health services supported by the project resulted in quick and substantial increases in service utilization. Because of this, focus began shifting further away from the community mobilization work as originally conceptualized (the Community Action Cycle) and more heavily onto supporting service delivery.

## MaMoni Health Systems Strengthening Project (2014-2018)

**MaMoni HSS Project Objectives:**

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 system
4. Identify and reduce barriers to utilization of health services

### *Transition from MaMoni ISMNC-FP to MaMoni HSS*

With the improvement of service utilization indicators seen during MaMoni ISMNC-FP resulting from supporting the provision of basic health services, the follow-on project—MaMoni Health Systems Strengthening (HSS)—focused even more extensively on increasing quality public sector service delivery and significantly streamlined its approach to community mobilization. The $53 million project was an Associate Award under MCHIP and covered a population of 12.5 million across six districts (Habiganj, Noakhali, Laksmipur, Jhalokati, Pirojpur, and Bhola). MaMoni HSS sought to support the Ministry of Health and Family Welfare (MOH&FW) to "introduce and leverage support for the scale-up of evidence-based practices already acknowledged in Bangladesh" to improve maternal and newborn health, family planning, and nutrition (MNCH/FP/N).[31]

### *Project's key community components*

#### *Shifting roles of Community Action Groups and Community Volunteers*

Although the Community Action Cycle approach had been shortened and simplified during MaMoni ISMNC-FP, it still required a large investment of resources and project staff support in order to monitor activities. With the shift in focus under MaMoni HSS towards supporting government systems, the structured Community Action Cycle was discontinued and Community Action Groups instead focused more directly on collecting vital event data to share during Community Microplanning Meetings and serving as forums for monthly health education messages. Thus, analysis of community information, the development of action plans, and review of resolutions to identified problems were undertaken primarily during microplanning sessions and not during CAG meetings.

Community Volunteers were trained and supported to facilitate the Community Action Groups, promote healthy maternal and newborn health, family planning, and nutrition behaviors and careseeking within their communities, and to liaise with FWAs and HAs during the monthly Community Microplanning Meetings. The catchment area per Community Volunteer was reduced to 250 population to make it even more feasible to remain in contact with constituents and to allow maximum participation of community members. Unlike MaMoni ISMNC-FP where the catchment areas of three CVs formed a Community Action Group, each Community Volunteer under MaMoni HSS facilitated their own Community Action Group.

#### *Further institutionalization of Community Microplanning*

Community Microplanning Meetings and union follow-up meetings were held as they were under MaMoni ISMNC-FP, however increasingly the government frontline service providers (FWAs and HAs) took on facilitation and reporting roles from project staff and provided their Community Microplanning Meeting reports directly to the Upazila Health Complex. In year four of the project, MaMoni HSS piloted involving the government mandated Community Support Groups as forums for Community Microplanning Meetings in three unions of three districts. They have expanded the piloting to three more districts in year five in anticipation of strictly implementing cMPM through this body in the next follow-on project.[31] Results available so far from the piloting indicate that the meetings were held regularly as planned, although the Community Health Care Provider (health service provider of the Community Clinic) was unable to attend all of the cMPMs in the Community Clinic catchment area (3-4 cMPMs per Community Clinic catchment area).

#### *Increased effort to engage local government*

MaMoni HSS continued to encourage local government bodies to engage with the public health sector and address barriers to service utilization. Project staff facilitated bi-monthly Union Education Health and Family Planning Standing Committee meetings of the Union Parishads in the project area. Project staff oriented local government officials

on their authorized roles and responsibilities as outlined by the Government of Bangladesh, which include the following: 1) they are to hold service providers in their union accountable and ensure they are not charging for services; 2) they are to help popularize the clinics and promote service utilization within their union; and 3) they are to mobilize resources to address MNCH, family planning, and nutrition needs within their communities. MaMoni HSS project staff ensured Union Parishad members and standing committee members were aware of the range of activities that were within their scope to support.

### *Key results*

*[At the time of this writing, MaMoni HSS was coming to a close and there was not a final report available. Therefore, key results highlighted here are preliminary.]*

At the time of the 4th Annual Report (September 2017), there were 23,929 Community Volunteers/CAGs active in the MaMoni HSS's high intensity intervention upazilas.[32] Of these CAGS, 18,452 had established emergency transport systems for MNCH care within their communities.[32] Health Assistants and Family Welfare Assistants were serving as facilitators and recorders for 85% of the Community Microplanning Meetings in the project areas.[32]

Engagement of local government has been a significant achievement of MaMoni HSS. By activating the Union Parishad standing committees and orienting them to their roles and responsibilities, MaMoni HSS was able to advocate for the allocation of greater proportions of their annual budgets to health, family planning, and nutrition-related activities. Table 3, taken from MaMoni HSS's 4th Annual Report, gives a snapshot of the budget allocations Union Parishads have recently made for such purposes.[32] In alignment with the current government sector plan that stipulates union-level facilities should be made functional, some Union Parishads have provided funds to deploy additional service providers (paramedics) in their Union Health and Family Welfare Clinics to fill vacancies. The greatest achievements have been in involving Union Parishads to mobilize funds to upgrade and ensure continuity of services at the Union Health and Family Welfare Clinics. Funds are primarily used for construction, facility repairs and maintenance, purchasing emergency medicine during stock-outs, purchasing small medical and non-medical equipment, work on approach roads to facilitate easier access to facilities, and supporting temporary support staff when needed (e.g. staff for crowd control during peak hours, cleaners, etc.).[32] Some Union Parishad Chairmen have begun visiting the UH&FWC on a daily basis to provide oversight and have striven to popularize the clinics by providing small birthday gifts to the babies born in the facilities. In the remote island of Hatiya, the local government's oversight and contributions to service improvement resulted in a five-fold increase in institutional deliveries between 2014 and 2017.[33]

**Table 3:** Union Parishad budget allocation and utilization (July 2016 to June 2017)[32]

| District | Number of Unions | Number of unions allocated budget | Percentage of unions allocated budget | Total budget allocated (BDT) | Total budget utilized (BDT) | Percentage of budget utilization |
|---|---|---|---|---|---|---|
| Habiganj | 77 | 57 | 74 | 7,298,945 | 4,449,311 | 61 |
| Jhalokathi | 32 | 21 | 65.6 | 3,080,069 | 1,009,640 | 33 |
| Lakshmipur | 58 | 42 | 72.4 | 6,035,208 | 5,887,871 | 98 |
| Noakhali | 44 | 38 | 86.4 | 4,518,000 | 6,260,098 | 139 |
| **Total** | **211** | **158** | **74.9** | **20,932,222** | **17,606,920** | **84.1** |

**Note: Fund utilization was lower due to Union Parishad elections during the year*

### *Key learnings and lessons taken forward*

MaMoni HSS's experience of engaging local government within communities has demonstrated the critical role such a body can play in removing barriers to service utilization. The Government of Bangladesh has made moves to commit itself to ensuring universal health coverage for its population over the next few decades, and has acknowledged MaMoni HSS's unique contribution towards this aim. The Ministry of Health and Family Welfare 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.[33] Union Parishad Chairmen who have been champions of this cause under MaMoni HSS have been provided forums by the MOH&FW to share their experiences and successes within their subdistricts so that additional unions may learn from their examples.

## Community mobilization at scale: Strengths and challenges

### Evolving approaches instep with shifting political priorities for health

Save the Children Bangladesh's approaches to community mobilization at scale did not evolve over time in isolation according to a strict ideology. Rather, the strategy evolved to address the gaps in community engagement approaches in the government program, and to facilitate the interface between communities and government health workers. Save the Children began by infusing tremendous project support and funding into establishing an initial heavily-structured model for community mobilization appropriate for the Bangladeshi context under ACCESS, and then subsequently streamlined the approach and sought ways to integrate it into existing systems at a national scale. The ACCESS project was designed and implemented during a time when the Government of Bangladesh had no strategy regarding the role of community mobilization in the health system and Community Clinics were shuttered. Now, community mobilization is part of the Government of Bangladesh's health strategy (included in the fourth sector-wide program), and government structures have been established to facilitate the engagement of community members and local representatives in identifying service gaps, providing facility oversight, and mobilizing local funds to address health and family planning needs within local communities. While many NGOs across Bangladesh had

their own models of community mobilization over the same time period, rarely were they integrated with the government system. Save the Children Bangladesh posits that this is their key contribution—learning from project experiences and successes along the journey that have highlighted unique opportunities for meaningful interfaces between government and communities and working to institutionalize those models at district and national scales.

*Community Action Groups and Community Microplanning*

Directly engaging community members through Community Action Groups under ACCESS showed promise for increasing demand for maternal and newborn health services and addressing basic barriers to accessing care. However, with a health system struggling to provide even basic services in many areas, Save the Children Bangladesh necessarily shifted emphasis in their programming to helping ensure government services were available. Aiming to support the government systems and work at increasing scale, it became quickly apparent that using project staff to intensively facilitate Community Action Groups to follow a complex Community Action Cycle process would no longer be the best use of project funding. Simplifying the tasks of Community Action Groups enabled uneducated group members and Community Volunteers to have successful and focused meetings and to take ownership of their meetings' results. They began focusing on collecting meaningful information directly useful for local planning by the health system, and through Community Microplanning meetings, gained the ability to directly interface with the system on a regular basis.

Arguably, it appears that the restructuring of Community Action Groups over time compromised the original focus on strengthening communities' capacity to identify and address their own issues in a broad sense—a capacity useful beyond the context of a specific project-driven health goal. However, it could be argued that even the more streamlined work of Community Action Groups and Community Volunteers provided opportunities to improve their sense of collective efficacy to influence local decision-making and address their prioritized problems. The establishment of Community Microplanning Meetings (cMPM) allowed for a previously unseen level of communication amongst community members and health and family planning service providers. Social autopsies showed that collecting information for cMPM was not just about simply registering pregnant women—rather, sharing of such information allowed for direct follow-up when women died. Community leaders visited the households where maternal deaths took place—which inadvertently helped to challenge the norm that being pregnant is just a woman's affair. Local leaders and the government health system were able to be directly responsive to the community's actual needs because of Community Action Groups' grassroots surveillance. Learnings from the cMPM experience have been leveraged to establish a team-based training program at the National Institute of Population Research and Training (NIPORT), through which the government's frontline providers (Female Welfare Assistants, Health Assistants, and Community Health Care Providers) learn to work more effectively together and improve data reporting within their catchment area communities.

Additionally, Community Volunteers' capacities were strengthened through orientation trainings and by being provided opportunities to liaise among community members and government outreach workers. Many Community Volunteers gained the ability to be considered for better jobs, or were elected to local government positions as their rapport with community members grew during their service.

*Engagement of local government*

Union Parishads are powerful non-health actors that Save the Children Bangladesh has successfully engaged to help mobilize local resources for health within communities in their project areas. Through MaMoni ISMNC-FP and MaMoni HSS, local politicians have received pressure to use Union Parishad money for health and family planning needs. This is a departure from their previously narrow focus on funding sanitation projects—which a few key informants said are known to allow more space for corruption. As a result, key informants involved in field implementation expressed how some local government representatives have developed a public reputation for being less corrupt in the eyes of their constituents, and are now compelled to keep up the reputation by continuing to direct funds towards health and family planning needs even in the absence of direct pressure from the project. As Community Volunteers from Save the Children Bangladesh's projects have gained respect in their communities and been elected as members in their Union Parishads, this momentum continues to grow.

Since local government officials are held accountable to their constituents and must maintain their reputations in order to be re-elected, they are ideally suited to provide oversight to the local health facilities and providers. Once they allocate funds to a local facility in response to needs identified by the community, they are invested in ensuring those funds are used appropriately. As a result of engaging local government in this way, Union Chairmen are now playing more active roles in visiting facilities, ensuring staff are present each day and services are functional. Based on Save the Children Bangladesh's model, the Government of Bangladesh has recently incorporated the engagement of local government to support union level facilities into the Ministry of Health and Family Welfare's sector plan. Using an advocacy toolkit they developed for this purpose, Save the Children Bangladesh is now supporting DGFP's direct implementation of the model in two priority divisions. Furthermore, MaMoni HSS sites have served as learning sites for other districts to visit and learn how the local government members were mobilized.

## Evaluating outcomes of community mobilization: Challenges in measurement

Key informant interviews revealed how project team members acknowledge in hindsight how it was misguided to originally focus so narrowly on tracking how many specific Community Action Groups were continuing to meet at regular intervals over the years and following the prescriptive Community Action Cycle process in detail. In practice, as government structures become more responsive to community needs over time, social norms gradually shift, and more women seek services at facilities, it is

reasonable that the very Community Action Groups originally established need not continue to meet every two weeks in a formalized way. Moreover, as the use of mobile phones has proliferated since ACCESS was first implemented (from 21.76 million users in 2006[34] to 143.103 million users as of November, 2017[35]), community members and volunteers have changed the ways in which they interact. No longer is it necessary to meet in person every time something needs to be communicated; rather community members can share information over the phone and even communicate with outreach workers of the government or elected representatives using their mobile phones. Projects should acknowledge this change and continue to innovate ways to incorporate mobile phone technology into their approaches to community mobilization.

ACCESS and MaMoni ISMNC-FP had comprehensive community mobilization strategies complete with ambitious community mobilization component specific objectives. However, progress towards these objectives was unable to be measured with the monitoring data collected. This challenge is not unique to the documented projects. As Lippman[36] highlights, community mobilization approaches are increasingly being used as components of health programs, yet they are often poorly evaluated. Moving beyond simple process indicators to measure the outcomes of community mobilization activities is challenging due to a lack of tools and constraints on time and funding. Community mobilization outcomes are latent (not directly observable) in nature, and require scales adapted to and tested within a project's local context in order to be measured reliably. Ideally, funding for projects implementing community mobilization approaches would also support operations research that could allow for the validation of measures appropriate for the project's context so that latent constructs such as collective efficacy, collective action, social capital, social cohesion, and others could be accurately and reliably measured at project baseline and endline. Moreover, since processes to facilitate community mobilization are lengthy and outcomes and impacts are not immediate, experience suggests that projects implementing approaches to community mobilization should not be less than five years in duration.

## Ways forward for future programming

Save the Children Bangladesh will soon begin implementation of the next follow-on project known as MaMoni Maternal Newborn Care Strengthening Project (MNCSP), which will continue through 2023. A $50 million USAID-funded project, MaMoni MNCSP will cover a population of roughly 21.5 million people across ten districts: Brahmanbaria, Chandpur, Lakshmipur, Feni, Noakhali, Faridpur, Manikganj, Madaripur, Kushtia, and Habiganj. MaMoni MNCSP aims to cut back project-driven activities even more drastically than MaMoni HSS and focus on how to support the government structures that have been more recently created to engage community members.

The new Community Support Groups that have been established by the Ministry of Health and Family Planning (three per Community Clinic) as a means of mobilizing

community members to participate in supporting the health system are not yet functional on their own, and do not have their own funds to directly address barriers to service delivery. In order to make these bodies active and sustainable, Save the Children Bangladesh recognizes the benefit of facilitating linkages between the Community Support Groups and local government bodies. Union Parishads have their own income and the authority to oversee government outreach workers and public health and family planning facilities, should they be motivated to do so. Since Union Parishad members are accountable to their constituents and have stake in ensuring local needs are addressed, they are ideal for taking on the role of ensuring Community Support Groups are functioning and mobilizing resources when necessary. In the project areas, MaMoni MNCSP will inject an initial investment into ensuring the government has the capacity to mobilize community members through their established structures, and then support as needed during the life of the project while taking care to avoid establishing parallel systems. Community Support Groups will take the place of project-specific Community Action Groups, community microplanning will take place through the Community Support Groups, and the newly established government cadre of Multipurpose Health Volunteers (MPV) will perform the roles of Community Volunteers. Although the MPV's full scope of work will differ from MaMoni's CVs, the Ministry of Health and Family Welfare could benefit from MaMoni's learnings regarding guidelines for selection, training, support and links to frontline workers. Save the Children in Bangladesh is already involved in discussions related to the establishment of the new MPV cadre, and the training manuals, registers, and job aids developed by MaMoni will be helpful to the Ministry.

Save the Children Bangladesh's experiences thus far have shown that engagement of local government in health can be tremendously successful in generating local resources and strengthening public facilities. However, moving forward it will be necessary to not only focus on how they can be leveraged to support community service delivery, but also the role they may play in shifting social norms and helping to create supportive environments for sustainable behavior change within households in their communities. Advocating that a portion of locally mobilized funds be invested in health promotion activities rather than solely towards infrastructure could be one way to help ensure a more integrated approach to supporting community health. Furthermore, the project has a long way to go in exploring how best to ensure local government officials are effectively seeking and processing feedback from their communities and that their engagement in the public health sector does not solely hinge on the proactivity and interest of the Union Chairman alone. Local elected officials hold influence in their communities, and the project will do well to better understand and capitalize upon the various pathways through which local government can effect change in regards to health. Developing a comprehensive social and behavior change strategy for the project that explicitly lays out the underlying theory of change through which local government is seen to result in desired outcomes will be crucial in helping to identify the most appropriate indicators for assessing the contributions of various project components.

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## ANNEX II: List of key informants

| Name | Designation | Organization |
|---|---|---|
| Imteaz Mannan | Sr. Advisor Advocacy and Communication, MaMoni HSS Project | Save the Children Bangladesh |
| Antje Becker-Benton | Team Lead/Senior Advisor Behavior Change & Community Health | Save the Children US |
| Joseph Johnson | Senior Advisor MNH | Save the Children US |
| Joby George | Chief of Part, MaMoni HSS Project | Save the Children Bangladesh |
| Shumona Shafinaz | Senior Advisor, Program Management; MaMoni HSS | Save the Children Bangladesh |
| Marufa Aziz Khan | Senior Manager, Operations Research; MaMoni HSS | Save the Children Bangladesh |
| Md. Eklas Uddin | Deputy Program Manager, Community Mobilization; MaMoni ISMNC-FP Project | Save the Children Bangladesh |
| Jatan Bhowmick | Deputy Program Director, District Implementation; MaMoni HSS Project (Formerly Deputy Program Manager MNH under ACCESS/Bangladesh) | Save the Children Bangladesh |
| Homayun Kabir | Health Director | Shimantik |
| Jamil Akhtar | Manager, SBCC | Save the Children Bangladesh |
| Mohammod Shihab Uddin | [Former] Upazila Coordinator, ACCESS and MaMoni ISMNC-FP | Shimantik |
| Mohammed Kamal Hossain | [Former] Deputy Manager, Community Mobilization, ACCESS/Bangladesh<br><br>[Current] Project Director, HOPE | Save the Children Bangladesh |
| Ishtiaq Mannan | Deputy Country Director | Save the Children Bangladesh |
| Rowshon Jahan | Manager, Community-based Services; MaMoni | Save the Children Bangladesh |

| | | |
|---|---|---|
| | HSS | |
| Md. Jalal Uddin | Upazila Facilitator Quality Improvement & Service Delivery; MaMoni HSS | Save the Children Bangladesh |
| Jesmin Akter | Upazila Facilitator Quality Improvement & Service Delivery; MaMoni HSS | Save the Children in Bangladesh |
| Bashir Ahammad | Senior Program Officer; Habiganj | Save the Children in Bangladesh |
| Angela Brasington | [Former] Community Mobilization Specialist<br><br>[Current] Senior Technical Advisor, Bureau for Global Health | [Former] Save the Children USA<br><br>[Current] USAID |

## ANNEX III: Sample key informant questions

*The following list comprises basic questions asked of all key informants. More specific probing questions were asked of each key informant in accordance with their role and knowledge of various project components.*

1. Can you tell me about your role in ACCESS/MaMoni/MaMoni HSS?
    a. Probe specifically on CM component
2. What was your understanding of the role CM played in ACCESS/MaMoni/MaMoni HSS? (e.g. What did you focus on and measure?)
3. Can you tell me your thoughts on how "mobilized" the communities became?
4. What did CM look like in ACCESS/MaMoni/MaMoni HSS? (And specifically what role did the CAGs play?)
    a. How did this compare to the way CM was conceptualized at the project's outset? (Compare to the CM strategy documents)
        i. Reasons for any deviations?
    b. What strategies were developed? What is still in use?
    c. What tools and materials were developed?
5. Can you tell me how this compared to previous iterations (ACCESS/MaMoni)?
    a. Reasons for evolution? (Who were the drivers? Actors?)
6. What constitutes successful CM?
    a. How is this measured?
    b. What gaps were there?
7. What challenges did the project face regarding CM?
8. What about the CM component worked well?
9. What lessons did you/your team/the project learn regarding the CM process as a result of the project? What lessons should be shared with others interested in implementing CM or taking it scale?
10. What is different about CM when implemented at a small scale vs. large scale?
    a. Why?
    b. What do we gain?
    c. What do we lose?
    d. How are the pros/cons weighed?

## ANNEX IV: Summary table

Increasing project **scale** and **institutionalization** of community mobilization

| | *Precursor research projects contributing to evidence base* | | *Three generations of USAID-funded MNH projects incorporating community mobilization activities by Save the Children in Bangladesh* | | | *New project* |
|---|---|---|---|---|---|---|
| **Project** | **SEARCH Field Trial [India]** (1995-1998) | **Projahnmo I Study** (2001-2006) | **ACCESS** (2006-2009) | **MaMoni ISMNC-FP** (2009-2013) | **MaMoni HSS** (2014-2017) | **MaMoni MNCSP** (2018-2023) |
| **Funding** | The Ford Foundation and The John D and Catherine T MacArthur Foundation | USAID and Save the Children's Saving Newborn Lives program through a grant from Bill and Melinda Gates Foundation | USAID<br>($6 million) | USAID<br>($13 million) | USAID<br>($53 million) | USAID<br>($50 million) |
| **Geographic scale (number of subdistricts)** | Gadchiroli District of Maharashtra State, India (39 intervention villages; 47 control villages)<br><br>Study population of 81,147 | Sylhet District (3)<br><br>113,816 study participants | Sylhet District (5)<br><br>Population of 1.5 million | Sylhet District (5)<br>Habiganj District (8)<br><br>Population of 3.5 million | **High intensity intervention areas:**<br>Habiganj District (8)<br>Noakhali District (4)<br>Laksmipur District (5)<br>Jhalokati District (4)<br>Pirojpur District (2)<br><br>**Health system capacity strengthening areas:**<br>Bhola District (7)<br>Noakhali District (5)<br>Pirojpur District (5)<br><br>Population of 12.5 million | Brahmanbaria District (9)<br>Chandpur District (8)<br>Lakshmipur District (5)<br>Feni District (6)<br>Noakhali District (9)<br>Faridpur District (9)<br>Manikganj District (7)<br>Madaripur District (5)<br>Kushtia District (6)<br>Habiganj District (8)<br><br>Population of 21.5 million |
| **Project objectives** | Test the hypothesis that a home-based package of newborn care, including the | Test the hypothesis that both a home-care model and a community-care model for promoting | **Objective 1:** Increase knowledge, skills, and practices of healthy maternal and newborn behaviors in the | **Objective 1:** Increase knowledge, skills and practices of healthy maternal and neonatal behaviors in the | **Objective 1:** Improve service readiness through critical gap management | TBD |

## ANNEX IV: Summary table


| | ***Precursor research projects contributing to evidence base*** | | ***Three generations of USAID-funded MNH projects incorporating community mobilization activities by Save the Children in Bangladesh*** | | | ***New project*** |
|---|---|---|---|---|---|---|
| | | in a comparison arm. (Baqui et al., 2008) | services<br><br>**Objective 3:** Improve key systems for effective service delivery, community mobilization, and advocacy<br><br>**Objective 4:** Mobilize community action, support, and demand for the practice of healthy MNH behaviors<br><br>**Objective 5:** Increase stakeholder leadership, commitment, and action for these maternal and neonatal health approaches | services<br><br>**Objective 3:** Increase acceptance of FP methods and advance understanding of FP as a preventive health intervention for mothers and newborns<br><br>**Objective 4:** Improve key systems for effective service delivery, community mobilization and advocacy<br><br>**Objective 5:** Mobilize community action, support and demand for the practice of healthy MNH behaviors<br><br>**Objective 6:** Increase key stakeholder leadership, commitment and action for these MNH approaches | strengthen district level health system<br><br>**Objective 4:** Identify and reduce barriers to utilization of health services | |
| **Key community components** | • Village health workers provided home-based newborn care including diagnosis and treatment of neonatal sepsis<br><br>• Health education provided to mothers and grandmothers regarding care of pregnant women and of neonates | • Community Mobilizers hosted community group meetings to disseminate birth and newborn care preparedness messages<br><br>• In the community-care arm, volunteer community resource people worked to encourage attendance at community meetings and care seeking for MNH | • Community Action Groups (CAG) facilitated by project staff and supported by Community Resource Persons (CRP)<br><br>• 1 female CAG and 1 male CAG per village<br><br>• CAGs followed intensive 11-month Community Action Cycle (CAC) | • Community Volunteers (CV) selected by Union Parishads to facilitate CAGs<br><br>• Community Action Groups (CAG) followed simplified 6-month CAC<br><br>• 1 CV per 300 population; 3 CVs per CAG<br><br>• Community Microplanning Meetings (cMPM) | • Community Volunteers facilitate monthly Community Action Groups (CAG) meetings to share health education; collect data to share during cMPM<br><br>• 1 CV per 250 population; 1 CV per CAG<br><br>• Community Microplanning Meetings (cMPM) | TBD |

## ANNEX IV: Summary table


| | ***Precursor research projects contributing to evidence base*** | | ***Three generations of USAID-funded MNH projects incorporating community mobilization activities by Save the Children in Bangladesh*** | | | ***New project*** |
|---|---|---|---|---|---|---|
| | | • In the home-care arm, CHWs visited households to provide ANC/PNC and treatment with injectable antibiotics | • Home visits by ACCESS Counselors (AC) | • Local government engagement | • Local government engagement<br><br>• Interactive community video shows | |
| **Lessons learned** | Home-based neonatal care, including management of sepsis, is acceptable, feasible, and reduced neonatal mortality by 62% among the rural study population | 33% reduction (home-care arm) and non-significant 9% reduction (community-care arm) in neonatal mortality showed that community-care model needs longer time period to become well established<br><br>Government cadre of CHWs not authorized to provide injectable antibiotics, therefore complete model not directly scalable outside research context | Model successful in increasing knowledge and demand for services, but not in improving key service utilization indicators due to unavailability of services | cMPM emerged as a promising interface between community and existing government structures | Local government became key resource for strengthening facilities and addressing barriers to service delivery | Not yet available |