Human Resources for Health (HRH) Project in Bangladesh

Final Report July 2012 – December 2016

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Canada

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List of Acronyms / Abbreviations

AHI	Assistant Health Inspector
ANC	Antenatal Care
BCC	Behaviour Change Communication
BDT	Bangladeshi Taka
BNC	Bangladesh Nursing Council
CBO	Community Based Organization
CC	Community Clinic
CG	Community Group
CM	Community Mobilizer
CS	Civil Surgeon
CSBA	Community Skilled Birth Attendant
CSG	Community Support Group
CSO	Community Based Organization
DCS	Deputy Civil Surgeon
DD-FP	Deputy Director-Family Planning DGFP
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District Hospital
DNS	Directorate of Nursing Services
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
ESD	Essential Service Delivery
ESDO	Eco-Social Development Organization
FeCHCP	Female Community Health Care Provider
FeHAs	Female Health Assistant
FP	Family Planning
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
FWVTI	Family Welfare Visitor Training Institute
GAC	Global Affairs Canada
GOB	Government of Bangladesh
GRRL	Gender Responsive Referral Linkage
HPNSDP	Health, Population and Nutrition Sector Development Program
HI	Health Inspector
HRH	Human Resources for Health
HS	Health Services
IEC	Information, Education and Communication
IMO	Intermediate Outcome
IPC	Inter-Personal Communication
KAP	Knowledge, Attitude and Practice
LAMB	Lutheran Aid to Medicine in Bangladesh
LGI	Local Government Institutions
MCH	Medical College Hospital
MCWC	Mother and Child Welfare Centre
MO	Medical Officer
MO MCH-FP	Medical Officer - Family Planning
MO-OB/GYN	Medical Officer - Obstetrics/Gynaecology
MoHFW	Ministry of Health & Family Welfare
NC	Nursing College
NGO	Non-Governmental Organization
NVD	Normal Vaginal Delivery
OGSB	Obstetrical and Gynaecological Society of Bangladesh
OHP	Over Head Projector
PHC	Primary Health Care
PNC	Postnatal Care
PU	Program Unit

PVE	Per Vaginal Examination
PWR	Participatory Wealth Ranking
RMO	Resident Medical Coordinator
RH-STEP	Reproductive Health Services Training and Education
S&PM	Supervision and Performance Reporting
SSC	Secondary School
TBA	Traditional Birth Attendant
TfD	Theatre for Development
UFPO	Upazila Family Planning Officer
UH&FPO	Upazila Health & Family Planning Officer
UHC	Upazila Health Complex
UNFPA	United Nations Population Fund
UP	Union Parishad
UP-SC	Union Parishad Standing Committee

Executive Summary

With the overall goal to *improve the maternal and neonatal health status of the poor in Bangladesh,* Human Resources for Health (HRH) project was implemented over a 5 year period, from July 2012 to December 2016. Global Affairs Canada awarded CAD$17.7M to Cowater International Inc., the lead firm, in a consortium of four agencies comprised of McMaster University School of Nursing, Plan International Canada Inc., and the Canadian Association of Schools of Nursing (CASN).

Plan International, in collaboration with four partner organizations, Obstetrical and Gynecological Society of Bangladesh (OGSB); Lutheran Aid to Medicine in Bangladesh (LAMB); Kumudini Hospital and Eco Social Development Organization (ESDO), implemented the fifth immediate outcome (Immediate Outcome 500) and the community component of the project, which focused on increased *awareness of and access to skilled birth attendants at the community level.*

The following activities were undertaken to achieve the outcome:

- Trained Public and Private/Non-Governmental Organization (NGO) participants as Community Skilled Birth Attendants (CSBA)
- Established CSBA supervision, performance monitoring, and reporting
- Implemented BCC strategy to promote CSBA services at the community level
- Established gender responsive referral linkages between CSBAs and health facilities

The project selected CSBA participants both from the public and private sectors as per established government criteria and guidelines. OGSB participated in the selection of the public sector participants and the HRH project team supported the selection of private sector participants in collaboration with local Health and Family Planning managers. A total of 134 participants were trained as Trainers (ToT). The trainers were selected from the MoH Department of Family Planning and Departments of Health Services, LAMB and Kumudini Hospitals.

A total of 1,665 CSBAs were trained by the HRH project (exceeding the original CSBA training target of 1,552) and the trainees were selected from 17 districts of Bangladesh (listed under Section 512.2). A total of 1,256 CSBAs were from the public sector, which included 230, Family Welfare Assistants (FWA); 231 Female Health Assistants (FeHAs); and 795 Female Community Health Care Providers (FeCHCP), while the remaining 409 were from the private sector. To train and meet set CSBAs targets the project partnered with three organization who led the training process; to achieve this OGSB utilized 15 government training centers while LAMB hospital and Kumudini Hospital used their own centers for training CSBAs.

HRH-trained CSBAs provided services at the community level for a period ranging from 3 months[1] to 37 months, which was dependent on the completion of their training. The total number of NVDs conducted and women who received PNC services within 2 days of delivery by HRH-trained CSBAs in the project period was 37,169 NVDs and 52,160 PNCs, respectively. The target at the beginning of the project of 30 deliveries and 30 PNC provided by CSBA per Year by Year 5 of the project was not achieved due to the downward trend in the total fertility rates (TFR)[2], meaning that there were fewer babies to be delivered, coupled with the presence of other service providers and different initiatives to increase the facility deliveries, which meant that women had more choices of service provider and location of delivery, resulting in decreasing need for CSBAs at the community level.

[1] The last group of CSBA graduates provided services for 3 months as it took 3 months to inform the community members of the role and availability of the CSBA graduates.
[2] The TFR reduced from 2.48 in 2010 to 2.2 in 2016

100 private sector CSBAs completed the Skill Enhancement Training in Year 4 from April 2015 to January 2016. The aim of this training was to build the confidence of those CSBAs who were only conducting a small number of vaginal deliveries in the community, and had not conducted many deliveries during the CSBA training.

Plan International Bangladesh piloted 3 interventions in Lalmonirhat District: Supervision and Reporting System, BCC strategy and Gender Responsive Referral. Supervision and Reporting was implemented from April 2014 to February 2016 and aimed to provide supportive supervision for the graduate CSBAs upon their return to the communities. To initiate the supervision, the project organized orientation programs in 45 unions of Lalmonirhat district where a total of 438 (165 male, 273 female) project actors from various levels of Ministry of Health and non-government organizations (NGOs) participated as Supervisors, Family Welfare Visitors, CSBAs, Assistant Health Inspectors, Family Planning Inspectors, and managers from DGFP and DGHS. The organization of monthly meetings to review CSBA performance and reporting was initiated and started in Years 3 and 4 of the project (2014 to 2015, under the leadership of FWV).

The project also oriented statisticians from the other 16 project districts on Supervision and Reporting which was followed by quarterly data collection and review meeting. The joint meeting between MoH statisticians, CSBAs, FWV and project staff, improved MNH data collection frequency and quality over the reporting period which started in June 2014. The competency measurement sessions conducted by the project identified 19 low performing CSBAs who required additional practical experience and were sent for clinical attachment at the district hospital or Mother and Child Welfare Center (MCWC) to improve their practical skills.

Under the project's BCC Strategy, the project developed several types of gender sensitive Information, Education and Communication (IEC) materials which included stickers, posters, wall calendars, desk calendars, message boards and sign-boards to be used by HRH trained CSBAs. 1,996 Theater for Development (TfD) sessions were conducted and 28 union level fairs and introduction sessions were held for the newly graduated CSBAs at the community. All of these activities and approaches were effective in raising awareness among the women of reproductive age and influencers[3]. This was reflected in a Knowledge, Attitude and Practice (KAP) surveys which were conducted in (baseline) October 2013 and (endline) November 2015 among selected populations on roles and functions of CSBAs, regarding pregnancy care and newborn health care in Lalmonirhat District after the implementation of the BCC strategy. The endline data showed that the situation had improved from the baseline for the major indicators. For example, 98.5% of women of reproductive age who had delivered recently[4] were aware of the presence of CSBAs in the union and 95.9% of them knew the responsibilities of CSBAs. These indicators were 21.3% and 24.5% respectively during the baseline survey. The endline survey also revealed that 45.3% of surveyed women who had recently delivered received ANC from CSBAs, 50.3% received PNC within 2 days of delivery and 70.5% received NVD services from CSBAs which were quite low at baseline (1.3%, 1.8% and 6.2% respectively).

The Gender Responsive Referral Linkage (GRRL) System was implemented from April 2013 to March 2015 in three Upazilas: Patgram, Kaliganj and Hatibandha, as an effort to mitigate one of the contributing factors to high maternal mortality in Bangladesh, which is the delay in accessing emergency obstetric-care (EmOC)[5] facilities. A total of 60 community groups (CGs) were trained on

[3] Mothers-in-law, sisters-in-law, fathers-in-law, husbands, community leaders, and religious leaders
[4] Women who had given live birth in the last 5 years

[5] https://www.guttmacher.org/journals/ipsrh/2007/06/maternal-health-and-care-seeking-behavior-bangladesh-findings-national-survey

the Gender Responsive Referral System with the training objectives to raise awareness of the CG members on the effects of gender-based discrimination and barriers on maternal and child health; on referral systems/protocols; and on promoting roles of CGs in strengthening referral systems. A similar training was provided to 85 CSBAs. The GRLL played a key role in i) motivating stakeholders at the local level to support and make referrals effective, ii) raising awareness for timely decision making and supporting poor families with referral services to reach facilities. The outcomes of training CGs also indirectly contributed to other GRRL objectives, such as: iii) improving relationships between CGs, health facilities and CSBAs, and iv) linking CSBAs and CGs in communities to enable them to understand each other's roles; share knowledge and skills; mobilize and utilize locally raised funds; and become jointly involved with the management of health facilities (CCs and FWCs) and services.

Two midterm reviews supported by Global Affairs Canada; the first midterm review was carried out in in 2014, the recommendation of which were integrated into the project implementation strategy and included in a sharing and learning meeting with the Senior MOH official, NGO and community representatives. As recommended by the midterm review, four CSBAs coordination meetings were conducted between May 2013 and September 2015 at the district level. These meetings created the opportunity for the project to conduct two National Level Workshops on the CSBA Supervision, Monitoring and Reporting System, where Senior officials from DGHS and DGFP and civil surgeons and DD-FPs from the 17 districts participated, which prompted discussions at the MoH on the need to strengthen the reporting system of CSBAs. The second midterm review conducted in 2015 acknowledged the role of the HRH project in piloting GRRL, BCC and Supervision as a project contributing to high awareness of CSBAs, MNH issues, more utilisation for delivery and other MNH services.

Three workshops were organized at the District level with the participation of the Civil Surgeon, DD-FPs, UH&FPOs, UFPOs, RMOs, MO-MCHs from District Hospital, MCWC and UHCs to strengthen the referral mechanism between CSBAs and the service providers at facility level. The project initiated the revitalization of Union Parishad (UP) Education, Health and Family Planning standing committees to support Gender Responsive Referral Linkages for maternal and newborn complications. This was followed by 4 sensitization workshops held in Kaligonj and Patgram Upazila in which health officials at the Upazila level participated. The expectation from the revitalization was to seek support from these establishments at times of emergencies, as well as to advocate for the CSBAs role in the communities.

Safety net support was provided to 15 families for emergency referrals, with amounts which ranged from BDT 1,000 to BDT 8,000. In addition, the project prepared referral slips for CSBAs and established referral registers in the referral centers. The shortage of staff at the secondary and tertiary hospitals, in part due to overburden/high workload, led to delays in patients receiving care as these centers were receiving patients from other non HRH-supported areas as well.

The project faced the following challenges:

- Project activities were hampered due to MOH finding it difficult to recruit and retain key positions at the Union and Upazila level (FWVs, MO-MCH, MO- OB/GYN) which were essential for supporting CSBA services and building their skills.
- Due to the limitation in the existing human resources, infrastructure and capacity within the Reproductive Health program, establishment of a 'training cell' for CSBA training planned during the project design was not a feasible option to conduct CSBA training in Bangladesh (this decision was made by MoH).
- Varying views on the viability of CSBA program versus midwifery training among the MOH directorates at local level.
- Supervisors of CSBAs focused more on reporting than supervision of CSBAs' performance due to limited human resources, incentives and required logistic resources.

- Limited availability of fully functioning 24/7 EmONC facilities and services at district and Upazila level reduced opportunities for CSBAs to enhance their skills due to a shortage of technical back-up and referral supports in their geographic coverage (within Upazila and/or District).
- Limited coordination between the two line directorates at the Union, Upazila and district levels (HS and FP). The project worked in close collaboration with both DGFP and DGHS from the CSBA selection process, which improved coordination at Upazila level and resulted in the decision to select CHCP as candidates for the CSBA training.
- Minimal capacity and investment in referral centres to provide referral services. The training of the 56 community groups focused on community engagement and participation, underscoring the need for support from community for referral services.
- There were no provisions of incentives (cash or in-kind) to CSBAs.
- Appropriate feedback mechanisms for referral services were not available.
- There were a total of 93 days of political strikes (Hartal) during the project implementation which limited the movement of project staff from Dhaka to the field. The project was able to mitigate potential delays challenges by working very closely with the community, MOH at Upazila and District level leadership.
- The recognition and utilization of the private CSBA was slow at the beginning, but the implementation of the BCC strategy increased awareness of the community members, which resulted in an increase in the utilization of services provided by the CSBAs.

As such, recommendations for future CSBA programming based on the midterm review and lessons learned are as follows:

- Directorate General Health Services (DGHS) to establish a coordination unit at central level, involving relevant stakeholders to foster better coordination to provide on-going support community based resources for services such as CSBAs.
- DGHS/DGFP to assign Upazila and district level focal persons to lead the CSBA program, including supervision, monitoring and reporting.
- DGHS/DGFP should consider strengthening EmONC facilities at district and Upazila hospitals and at MCWC, and making them available 24/7.
- Continue and/or replicate CSBA performance review through supervision, monitoring and capacity development, using the model piloted by the HRH project.
- Support the provision of incentives and/or rewards and replenishment of basic supplies to CSBAs, especially the private CSBAs to ensure quality of their services.
- Establish a feedback mechanism at all levels (Community Clinic, Health Centre to District Hospital) for referral centres to identify strengths and weaknesses in referral system.
- Community Group leadership should be encouraged by UHC to continue support to private CSBAs for referral of patients, mobilization of resources to support poor families, and availability of local resources to improve facilities and services in CCs.
- Establish closer coordination amongst the organizations training CSBAs to share lessons and challenges.

Section 1: Project Description and Results Achieved

1.1: Project Description

The Human Resources for Health (HRH) Project in Bangladesh was a Global Affairs Canada (formerly DFATD) funded 5 year project which supported Government of Bangladesh (GOB) strategies to:

- Produce skilled and competent nurses;
- Improve quality assurance in nursing education, and efficient management of nursing services; and
- Increase the number of trained Community Skilled Birth Attendants (CSBAs).

The ultimate goal of the project was **to improve the maternal and neonatal health status of the poor women, girls and boys in Bangladesh.**

Cowater International led a consortium of four executing agencies where Plan International (through its Canadian and Bangladesh offices) was one of the executing agencies implementing the fifth immediate outcome (Outcome 500) of the community component of the project, which was *Increased awareness of and access to skilled birth attendants at the community level.*

Under this immediate outcome, Plan International Bangladesh worked with DGHS and DGFP and contributed in helping to fulfill the HPNSDP target of CSBA training. Plan International Bangladesh partnered with three non-governmental organizations to train the targeted number of CSBAs, as well as to implement three pilot components to achieve the immediate outcome of the project. The NGOs were Obstetrical and Gynecological Society of Bangladesh (OGSB); Lutheran Aid to Medicine in Bangladesh (LAMB) Kumudini Hospital; to train the targeted number of CSBAs, and Eco Social Development Organization (ESDO), to implement three pilot components. These three components were implemented in Lalmonirhat Districts during the third and fourth year of the project, within the MoHFW structure, and by mobilizing and supporting Local government and Community Groups (CGs):

- CSBA supervision, performance monitoring and reporting
- BCC strategy to promote CSBA services at community level
- Gender responsive referral linkages between CSBAs and facilities

1.2: Results Achieved

Number of CSBAs trained

Plan International Bangladesh, in partnership with OGSB, LAMB, and Kumudini Hospital, conducted 91 batches (70 batches for Government participants and 21 batches for private participants) of CSBA training throughout the project period. The HRH project completed CSBA training in June 2016 and trained 1,665 CSBAs, which exceeded the original target of 1,552. Out of these trainees, 1,256 were from the public sector and 409 were from the private sector. The graduate CSBAs provided services at the community level for a period ranging from 3 months to 37 months, depending on the time of their training completion. Though the rate of report submission by CSBA increased significantly over the years, the downward trend in the total fertility rates (TFR)[6], meaning that there were fewer babies to be delivered, coupled with the presence of other service providers and different initiatives to increase the facility deliveries, which meant that women had more choices of service provider and location of delivery (contributing to the decrease in the use of CSBAs services at the community level).

[6] The TFR reduced from 2.48 in 2010 to 2.2 in 2016

As per the PIP, overall implementation of IMO 500 was to be completed in December 2016. Due to currency exchange losses that were projected during the AWP of Year 5, the project drafted a revised plan for this Immediate Outcome and as such, completed the majority of activities by June 2016 and adopted an alternate approach to capture data for CSBA deliveries and PNC from July-December 2016 as presented in Annex 5. For this reason, Plan International Bangladesh ended the MOU with the local implementing partners in July 2016.

Table 1: Summary status of NVD and PNC conducted by HRH trained CSBAs

Indicator	Baseline	Targets Established	Achievement			
		By End of Project	Year 2	Year 3	Year 4	Year 5 (3 Months Performance, April to June 2016)[7] with extrapolation to full year
Number of births conducted by HRH trained CSBAs in selected communities	0	30 deliveries per year per CSBA after completion of training	11	15	14	3.90 (16)
Number of women receiving PNC within 2 days of delivery from HRH trained CSBA in selected communities (HPNSDP, RFW, p.30)	0	30 PNC service contacts per year per CSBA after completion of training	17	21	19	5.39 (22)

Note: *The achievements are reported against the target set per year per CSBA as agreed in the project PMF.*

IMO 500 Indicator # 1

Number of births conducted by HRH trained CSBAs in selected communities

The average number of deliveries conducted by a CSBA per year for the project period was 14 NVDs. The total number of NVDs conducted by HRH-trained CSBAs in the project period was 37,169 NVDs. The number of deliveries reduced slightly in Year 4 when compared to Year 3 as a result of the project's effort to increase the quality and accuracy of the CSBA performance reports. A new position (MIS Coordinator) was added to the project team in Year 4, which allowed the project to extend its mobility to support physical verification of CSBA performance reports. This initiative reduced the traditional target based reporting, as it was discovered that UH and FP managers had set a targets of 5 deliveries/CSBA/month after their training, which was not realistic as declining TFR trends were not

[7] Data extracted from DHIS2 for July – December 2016 period is in Annex 5 of this report; this is showing the performances of all CSBAs in the project districts including HRH trained CSBAs.

considered. The CSBAs also informed the project monitoring team that they were reporting against the target set by UH and FP managers, whether they conducted the deliveries or not. These observations were shared with District and Upazila level Managers who reiterated that the CSBAs are required to report against the actual numbers of deliveries conducted.

The number of NVDs per CSBA did not reach the targeted 30 NVDs/CSBA due to the following reasons:

- The role of CSBA is an additional workload for the frontline government staff who were assigned CSBA responsibilities in addition to the primary role of FWA, and were not compensated with additional income or benefits for their extra work;
- Most of the public (MOH) CSBAs reside far from the assigned health facility so it was difficult for them to support deliveries which occurred at night or early in the morning given the security challenges associated with going back and forth during late hours (hence the public CSBAs provided ANC and conducted deliveries that occurred during their working hours).
- Absence of an appropriate level of supervision, support and logistics, for trained CSBAs.
- Downward trend in the total fertility rates (TFR)[8], meaning that there were fewer babies to be delivered, coupled with the presence of other service providers and different initiatives to increase the facility deliveries, which meant that women had more choices of service provider and location of delivery, which resulted in decreased need for CSBAs at the community level.

However, the average number of NVDs increased over the project period. The total number of deliveries by HRH trained CSBAs from Year 2 to 5 at the community level was 37,169 NVDs (Y2: 3,866, Y3: 9,824, Y4: 18,431 and Y5 (Q1): 5,048). The average number of deliveries per CSBA per year was 11 NVDs in Year 2, 15 NVDs in Year 3, and 14 NVDs in Year 4 (In Year 5, the project collected HRH trained CSBAs reports from April 2016 to June 2016[9]; from July 2016 data reported in Annex 5 includes data collected by the government across the project locations which includes CSBAs trained by organizations, e.g. Save the Children, BRAC etc.). Until June 2016 1,568 CSBAs had the opportunity to provide services in the community and reported regularly. However, in Year 5, only 1,296 CSBAs provided their performance report which was 83% of total CSBAs. This reporting percent was less than Year 4, where 93% CSBAs provided their services. Table 2 shows that the (cumulative) number of graduate CSBAs increased over the year from 535 CSBAs in Year 1 to 1,106 in Year 2, 1,474 in Year 3 and 1,665 Years 4/5.

Table 2: Number of births conducted by HRH trained CSBAs in selected communities

Reporting Year	Type of CSBAs	Number of CSBAs Trained	Number of CSBAs who had scope to perform	Number of CSBAs who submitted report	Number of NVDs conducted	NVDs/ CSBA/ Year
Year 2 (April' 13 to March'14)	Public	380	230	230	3,091	13.44
	Private	155	115	115	775	6.74
	Total	**535**	**345**	**345**	**3,866**	**11.21**
Year 3 (April' 14 to	Public	851	672	469	7,627	16.26
	Private	255	214	181	2,197	12.14

[8] The TFR reduced from 2.48 in 2010 to 2.2 in 2016

[9] This data shows the average 3 month performance of each CSBA and reflects that the extrapolated annual number of NVD would be 16 against the target of 30 NVD per year in Year 5 of the project.

March'15)	**Total**	**1,106**	**886**	**650**	**9,824**	**15.11**
Year 4 (April' 15 to March'16)	Public	1,102	1,063	999	13,899	13.91
	Private	372	352	313	4,532	14.48
	Total	**1,474**	**1,415**	**1,312**	**18,431**	**14.05**
Year 5 (April' 16 to June'16)	Public	1,256	1,179	1007	3,731	14.84
	Private	409	389	289	1,317	18.24
	Total	**1,665**	**1,568**	**1,296**	**5,048**	**16.54**
Overall					**37,169**	**14.22**

There was no formal CSBA performance reporting mechanism in the early stages of the project (the dedicated MIS officer to collect and validate data collected by CSBAs started in Year 4 of the project), so there was a possibility that the initial performance data had some errors. In Year 2, the CSBA performance was reported on a quarterly basis for the private sector through CSBA meetings, whereas the data collection for public sector CSBAs was through direct communication with individual CSBAs. However, from Year 3, the project established a formal reporting mechanism engaging the Upazila and District level Statisticians for collecting CSBA performance data from their respective Upazila/Districts. The project also provided reporting forms and registers for recording the CSBA performance data, which was complemented by training on reporting for the CSBAs and Statisticians. The monitoring system was strengthened and data validation was implemented through physical site visits by project teams and the review of data during meetings with statisticians. Therefore, the quality of CSBA performance data improved over the project period.

Private CSBAs' performance increased gradually, considering that they were not as well known to the community as their counterparts in the public sector were. As a result of BCC activities, such as TfD and CSBA introductions to the community through meetings, CSBAs' visibility and utilization of their services increased over the course of the project.

IMO 500 Indicator # 2

Number of women receiving PNC within 2 days of delivery from HRH trained CSBA in selected communities.

Similar to NVDs, the average number of women receiving PNC per CSBAs per year was 20 (refer to Table 3 below for annual breakdown) however this did not reach the target number of 30 PNCs per CSBA per year for the same types of reasons outlined above for IMO 500 Indicator # 1. The total number of PNCs conducted by the HRH trained CSBAs in the community within 2 days of delivery were 52,160 PNCs (5,707 in Year 2, 14,206 in Year 3, 25,258 in Year 4 and 6,958 in Year 5Q1). The average number of PNCs conducted by CSBAs per year was 17 in Year 2, 21 in Year 3, 19 in Year 4 and 21 in Year 5. The reasons the CSBAs conducted more PNCs than deliveries was that the CSBAs need time to be known and build trust after returning to the community; and at the beginning they felt more comfortable providing PNC services than delivery services.

Table 3: Number of women receiving PNC within 2 days of delivery from HRH trained CSBA in selected communities

Reporting Year	Type of CSBAs	Number of CSBAs Trained	Number of CSBA had scope to perform	Number of CSBAs submitted Report	Number of PNC conducted	PNCs[10]/ CSBA/ Year
Year 2 (April' 13 to March'14)	Public	380	230	230	4,840	21.04
	Private	155	115	115	867	7.54
	Total	**535**	**345**	**345**	**5,707**	**16.54**
Year 3 (April' 14 to March'15)	Public	851	672	469	11,197	23.87
	Private	255	214	181	3,009	16.62
	Total	**1,106**	**886**	**650**	**14,206**	**21.86**
Year 4 (April' 15 to March'16)	Public	1,102	1,063	999	19,834	19.85
	Private	372	352	313	5,424	17.33
	Total	**1,474**	**1,415**	**1,312**	**25,258**	**19.25**
Year 5 (April' 16 to June'16)	Public	1,256	1,179	1,007	5,453	21.68
	Private	409	389	289	1,536	21.56
	Total	**1,665**	**1,568**	**1,296**	**6,989**	**21.62**
Overall					**52,160**	**19.82**

[10] This data shows the average 3 month performance of each CSBA and reflects that the extrapolated annual number of PNC would be 21 against the target of 30 PNC per year in Year 5 of the project

Section 2: Operations

2.1: Progress on Implementation

Output 510 – Strategic Activities

Activity 511: Conducting needs assessment: to review recent evaluations of the Community Skilled Birth Attendant (CSBA) training program, identification of key gaps related to training and supervision of CSBAs, and an assessment of technical, material and financial support required to address these gaps.

This activity was carried out before the selection of the HRH Outcome 500 commenced the selection of the CSBA's. The main reason for the assessment was to avoid duplication and to ensure the selected candidates had not undergone the CSBA training previously.

Activity 512: Train government and NGO and/or private health workers as CSBAs at accredited and approved CSBA training sites in Bangladesh utilizing flow through funds (tuition and materials)

Sub activity 512.1: Provide Technical assistance to develop/strengthen a training cell under Director General of Health Services

Plan International Bangladesh was responsible for conducting a CSBA training program under the HRH project in training institutions accredited by the Bangladesh Nursing Council (BNC). To have a sustainable, feasible and effective CSBA training process, Plan International Bangladesh, with the support of Plan International Canada and Cowater International, were to work with the Director General Health Services to strengthen a 'training cell' within the Reproductive Health program under Director PHC and Line Director ESD (Essential Service Delivery) that would be able to manage the trainings of CSBAs in Bangladesh under Directorate General Health Services.

A discussion on the establishment of this training cell was held on 10 February 2013, between Plan International Bangladesh and Director, Senior MoH officials from DGHS and DGFP and it was indicated that due to the limitation in the existing human resources, infrastructure and capacity within the Reproductive Health program, establishment of a 'training cell' for CSBA training was not a feasible option to conduct CSBA training in Bangladesh. The TOT was instead conducted for the training institution partners selected as CSBA trainers from Kumudini, LAMB and OGSB.

Sub activity 512.2: Organize training of CSBAs from public and private sector candidates through OGSB, Kumudini and LAMB hospitals

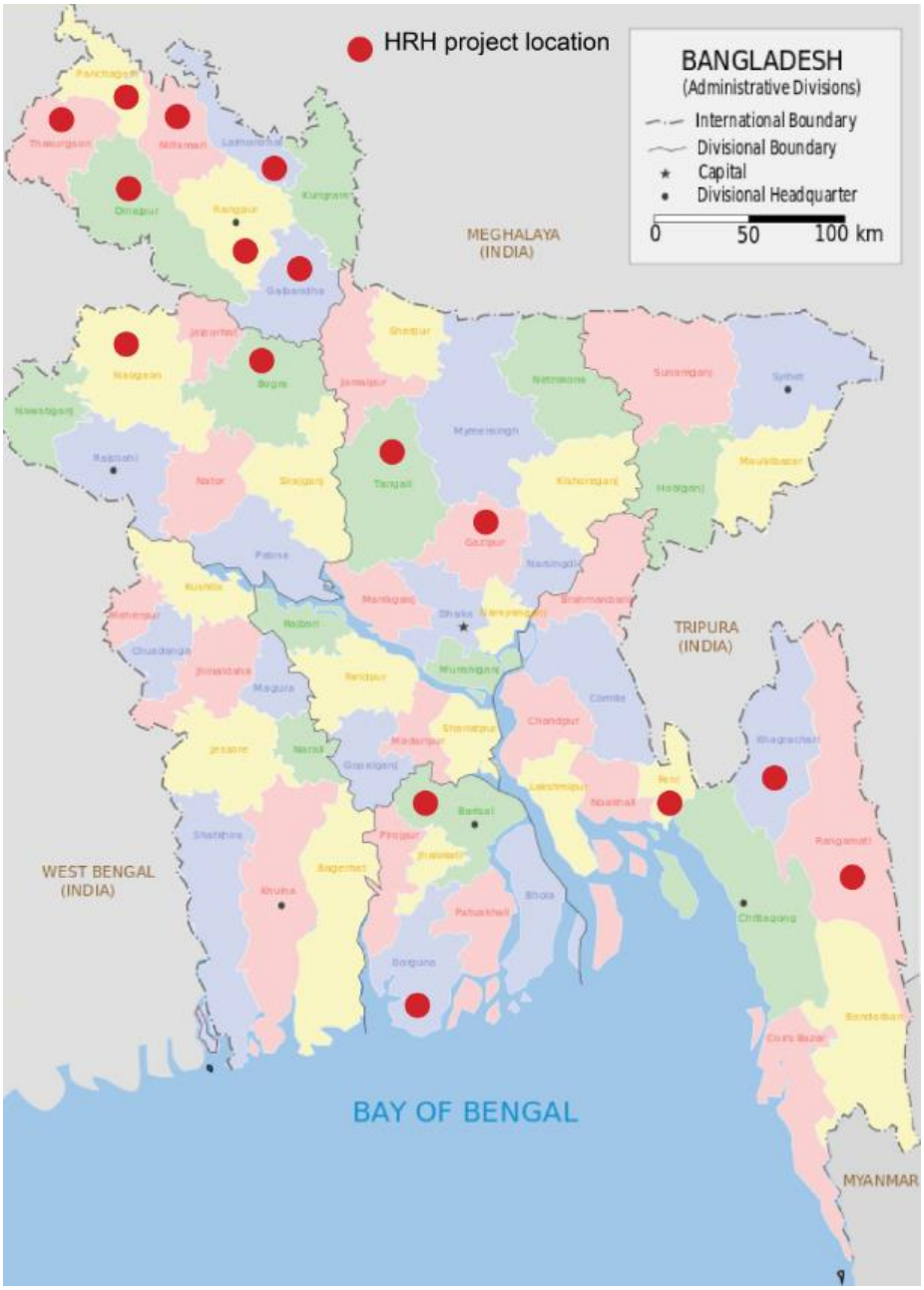
Plan International Bangladesh signed separate Memoranda of Understanding (MoU) with OGSB, LAMB Hospital and Kumudini Hospital to provide CSBA training to public and private sector candidates. The trainees were selected from 17 districts (Barisal, Barguna, Bogra, Dinajpur, Feni, Gaibandha, Gazipur, Lalmonirhat, Kurigram, Khagrachari, Nilphamari, Naogaon, Panchagarh, Rangamati, Rangpur, Thakurgaon and Tangail) through the

Picture 1: CSBA Training Session

partner organizations. A total of **1,665** (all female) trainees were trained as CSBAs under the HRH project. These trainees were selected from 17 districts and from the 7 districts as anticipated during the project development stage. The reason being that the 7 districts had a limitation in candidates meeting the MOH CSBA selection criteria's.

OGSB was responsible for providing CSBA training to mainly public sector participants (Family Welfare Assistant (FWA); Female Health Assistant (FeHAs) and Female Community Health Care Provider (FeCHCP)). However, in Year 4 of the project, they also trained 4 batches of private sector CSBAs.

Figure 1: Map of Implementation Areas



OGSB trained 74 batches with a total of 1,331 CSBAs, from 17 districts (230 FWAs; 231 FeHAs, 795 FeCHCPs and 75 from the private sector). The private sector CSBAs were from Barguna, Nilphamari, Khagrachari and Kishoreganj districts. LAMB Hospital trained 11 batches with a total of 217 private

CSBAs, from Lalmonirhat, Nilphamari, Dinajpur and Rangpur districts. Kumudini Hospital trained 6 batches with a total of 117 private CSBAs, from Lalmonirhat, Nilphamari and Gazipur districts.

OGSB was responsible for coordinating and facilitating the selection process of the public sector trainees, such as CHCPs, FeHAs and FWAs, following national standard selection criteria and through standard processes described below under Section 512.3. Plan International Bangladesh facilitated the process of private trainees' selection according to the above mentioned national criteria. Selection was done by involving Community Groups, Union Parishad and Upazila level health and family planning authorities.

Table 4: Summary Status of CSBA Training

Sl. No.	Name of the Partner	Number of Batch Conducted	Category of participants		Total Number of CSBA Trained
			Public	Private	
1	**Obstetrical and Gynecological Society of Bangladesh (OGSB)**	74	1,256	75	1,331
2	**Lutheran Aid to Medicine in Bangladesh (LAMB)**	11	-	217	217
3	**Kumudini Hospital**	6	-	117	117
Total		**91**	**1,256**	**409**	**1,665**

Note: *One CSBA under OGSB trained for 6 months but did not attend the final examination due to illness (cancer) and, for this reason, she has not been counted*

The Project emphasized on the quality of CSBA training, especially on the practical skills of the trainees, as the CSBA training is skills based training. The project discontinued its partnership with Kumudini the Year 3 of the project due to the limited opportunities for CSBA to conduct deliveries, making it difficult for the CSBA to achieve the set targets of deliveries before graduation.

Sub activity 512.2.1: Skill Enhancement Training for 100 Private CSBAs through OGSB

During implementation of the supervisory and reporting system pilot, it was discovered that the performance of some CSBAs was relatively poor due to their lack of confidence in conducting NVDs, resulting from limited opportunity to conduct deliveries and requisite support to reinforce the practical skills. For this reason, a 20 day Skill Enhancement Training initiative was taken in order to build the confidence and skills of these private CSBAs. 10 batches of skill enhancement training with 100 private sector CSBAs were completed in Year 4 at Rangpur Medical College Hospital from April 2015 to January 2016. During Skill Enhancement Training, theoretical refresher training was provided to the trainees and an average of 11 NVDs, 23 ANCs, 15 PNCs, 13 Newborn Care (NBC) and 21 Per Vaginal Exams (PVEs) were conducted per CSBA at Rangpur Medical College Hospital.

Sub activity 512.3: Facilitate the process of selection of trainee as per MOHFW guidelines through OGSB, Kumudini and LAMB

Trainees, both Public and Private sector, were selected according to the national standard selection criteria. Approval for training of **public** sector CSBAs (FWAs, FeHAs and FeCHCPs) from 17 districts (as listed under 512.2) was obtained from the MoH and the MoH was key in coordinating and facilitating the selection process of the public sector trainees, including CHCPs, FeHAs and FWAs. The selection criteria process involved:

- Approval of training would be obtained from Directorate General of Health Services (DGHS);
- A joint call-up notice was issued from the DGHS and Directorate General of Family Planning (DGFP) to respective Upazila Health & Family Planning Officers (UH&FPO) and Upazila Family Planning Officers (UFPO) through Civil Surgeons and Deputy Director - Family Planning at district level;
- UH&FPOs formed and led the selection committee;
- All the CHCPs, FeHAs and FWAs who did not receive CSBA training were called at the respective Upazila Health Complex (UHC). The committee selected the eligible trainees according to the national standard selection criteria:

    - FWAs and FeHAs
    - Aged 20 to 45 years
    - Minimum SSC education
    - More than 2 years of service experience
    - Maturity in approach/attitude and comfortable in addressing and working in reproductive health
    - Must be residing in the place of posting
    - Willing to stay for 6 months at the district for training
    - Willing to work as SBA for at least 5 years after the training
    - Willing to provide service at any time whenever she is called for emergency
    - Acceptable to the community

- After selection, a Government Order (GO) was issued from DGHS and DGFP through the Civil Surgeon and Deputy Director - Family Planning to the selected trainees informing them to participate in the training at selected venues.

Plan International Bangladesh, supported by partner organizations, facilitated the selection process for the **private** sector trainees from Plan Program Unit areas Barguna, Dinajpur, Gazipur, Lalmonirhat, Khagrachari, Nilphamari and Rangpur. The selection criteria of private sector CSBAs were:

- Female (preferably married)
- Age: 20-40 Years
- Minimum SSC education
- Willingness to participate in 6 month residential training
- Resident in the project area at least over the last 3 years
- Committed to serve the local community for at least 3 years after completion of training
- Written and oral examinations

Picture 2: Private CSBA selection process: written examination

At the beginning of the private CSBA selection process, the project sought the approval of the Community Groups (CGs) through discussions during their monthly meetings. Following the approval of the CGs, trainee selection notice was circulated at the community level. Each CG proposed 3 names (each of the 3 Community Support Groups (CSG) of a Community Clinic proposed one name from their area). A Community Mobilizer (CM) or partner staff on behalf of CGs, collected CVs and cross checked the papers, such as SSC certificates (where possible verified from respective schools), birth certificates (verified from UP), national ID, and other critical criteria. A list of potential participants was prepared and they were invited to participate in written and oral examinations. The CSBA

selection committee (Representatives of Civil Surgeon, UH&FPO, UFPO, Senior staff Nurse of UHC, Partners and Plan International Bangladesh) conducted the examination and on the basis of merit, a final list of CSBAs was prepared (20 CSBAs per batch). The final list was submitted to the training organization to provide CSBA training.

Sub activity 512.4: Selection of training sites and obtaining MOHFW approval

The training venues accredited as CSBA training centers by the Bangladesh Nursing Council (BNC) are based on the number of trainers, case load, teaching capacity, and learning resources. The needs assessment carried out by the HRH project showed that there were 41 training centers (including 2 private centers: LAMB and Kumudini) accredited by GOB to provide CSBA training in Bangladesh. The project explored opportunities to utilize these centers and communicated with relevant government health officials, such as DGHS, to request the utilization of these training institutions for the HRH project. Most of the centers had an ongoing CSBA training in session, limiting the available training centers to 12 for the HRH project. The HRH project supported MOHFW to accredit 3 more centers: Rangpur NC, Dinajpur NI and Bogra FWVTI, which were allocated to the HRH project to ensure training of CSBAs in the project areas, raising the total training centers leveraged by the project to 15.

Sub activity 512.5: Organize TOT for CSBA trainers

In each district training center there are usually 15 trainers. District trainers received training on the teaching methodology through TOT of CSBA training. District trainers were consultants (Obs/Gyn), consultants (Pediatrics), Medical Officers (Obs/Gyn), Assistant Directors, Deputy Civil Surgeons, Resident Medical Officers, Medical Officers (Clinic), Medical Officers (MCH-FP) of MCWC, Nursing Instructors (In charge), and nurses working in the labour ward and FWVs of MCWC. At the beginning of the project, it was observed that most of the centers lacked sufficient number of CSBA trainers due to transfer of trainers to other departments. To close the trainers' gap, the project, with technical assistance from OGSB, organized 8 batches of TOT for **134** trainers from MoH, LAMB and Kumudini Hospitals. The TOT contributed to the quality of CSBA training but over the project period, these trainers were transferred by the MOH, which led to a shortage of CSBA trainers in the project districts.

Table 5: Training Center status (Accommodation, Class room & Clinical)

Sl #	Training Centers	Accommodation	Class room	Clinical practice
1	Barisal	Nursing Institute	RH-STEP	MCH,DH& MCWC
2	Bogra	FWVTI, Rented house	FWVTI, Sadar UHC	DH & MCWC
3	Cox's bazar	Doctor's quarters	Nursing Institute, Sadar UHC	DH & MCWC
4	Dinajpur	RH-STEP	RH-STEP	MCH,DH,MCWC
5.	Feni	Nursing Institute, Rented house	Nursing Institute	DH & MCWC
6.	Gaibandha	Doctor's quarters	DH conference room	DH & MCWC
7	Joypurhat	Nursing Institute	Nursing Institute	DH & MCWC
8	Kurigram	Nurses dormitory	Nursing Institute	DH & MCWC
9	Nilphamari	Nurses dormitory	Nursing Institute	DH & MCWC

10	Naogaon	Nurses dormitory	Nursing Institute	DH & MCWC
11	Panchagarh	Doctor's quarters	Nursing Institute	DH & MCWC
12	Patuakhali	Nursing Institute	Nursing Institute	DH & MCWC
13	Rangpur	Nurses dormitory	RH-STEP	MCH,DH & MCWC
14	Thakurgaon	Doctor's quarters	Sadar UHC	DH & MCWC
15	Tangail	FWVTI, Rented house	FWVTI, Con. Room C/S	DH & MCWC

The attrition rate of CSBA trainees was low throughout the project period. Among the CSBA trainees, four from government (public) and seven from private sector dropped out from the training. The reasons for dropout included trainee or family members illness and, two private CSBAs had submitted false certificates therefore they were discontinued from the training as they were deemed ineligible.

Activity 513: In collaboration with MOHFW, DGHS, DGFP and other stakeholders, identify ways to provide supportive supervision for graduate CSBAs when they return to their communities.

Sub activity 513.1: Identify gaps and suggest alternate supervision plan for both public and private sector CSBAs

CSBA training was initiated in 2013 to train community level health (FeHAs) and family planning workers (FWA) on a well-developed curriculum, recognized by WHO Bangladesh. The training was later extended to FeCHCPs and Private/NGO participants. The Directorate General of Health Services (DGHS), in collaboration with the Directorate General of Family Planning (DGFP), as well as NGOs, had previously trained a significant number of CSBAs who were no longer actively providing services at the community or facility level thus the need to identify and establish a supervision plan. Underlying factors such as poor technical supervision, weak reporting mechanisms, limited logistical support and lack of referral linkages between CSBA and health facilities were identified as being responsible for CSBAs' limited contribution to skilled attendance of deliveries at the beginning of the project.

A supervisory and reporting mechanism started in April 2014 to March 2015, and the pilot recommendation included identifying FWVs as the clinical supervisor at the union level to support and supervise both Female Health Assistants (HAs) and FWA CSBAs. A coordination mechanism for supportive supervision was also suggested at the Upazila level to lead the activities and compile the reports but this was not done due to lack of resources from the GOB. However, with time, the need for establishment of an acceptable and effective *Supervisory and Reporting system* of the CSBA function became evident through various program evaluations and stakeholder workshops, including the mid-term review recommendation.

Therefore, to prepare an alternate supervision model, Plan International Bangladesh, with support from Cowater International Inc., initiated a short term consultancy using national experts with relevant experiences. The consultant proposed a supportive supervision system with emphasis on clinical supervision CSBAs, to ensure that the existing line of supervision through the DGHS, DGFP or NGO sector, with necessary adaptation for coordination, was to be utilized. The existing field supervisors were not considered technically skilled to undertake clinical supervision of community level midwives like CSBAs. However, they could support and oversee their overall performance of relevant tasks like pregnancy registration, ANC, safe delivery, PNC, neonatal care, referral and BCC activities. An

Upazila-based mechanism was proposed to strengthen clinical supervision of the CSBAs. It was proposed and agreed that FWVs, who are clinically competent midwives working at Union facilities (UH&FWC), would be clinical mentors/supervisors for all categories of CSBAs (Female HA, FWA, NGO or private sector) working within their Union. The job descriptions of FWVs were modified by incorporating the new function of clinical supervision of CSBAs at the Union-level and of reporting to the Upazila-level through MO-MCH FP. The supportive supervision of CSBAs was emphasized at Upazila-level and below, while the District and national levels remained the overarching umbrellas for all support and policy guidance.

The supportive supervision of CSBAs was planned to be focused at the community, Union and Upazila levels. Based on the nature and content of supervision, two categories were proposed:

i. Performance supervision, and
ii. Clinical supervision.

At the district and national levels, the supervision and monitoring of CSBA services was planned to be part of the routine supervision by their own line directorates, while NGOs were to maintain their own line of supervision. The supervisors at the Upazila level were identified through consensus at the national and sub-national level. The roles and responsibilities of the supervisors were also defined. As such, it was proposed that the supervisors perform supervisory activities by adjusting and integrating them into their own work under the guidance of senior officers from the MoH. The existing line of supervision and the supervisors by cadres at the field level role was to create an enabling environment for the CSBAs to work. The new role of the supervisors was proposed to be incorporated into their existing job description.

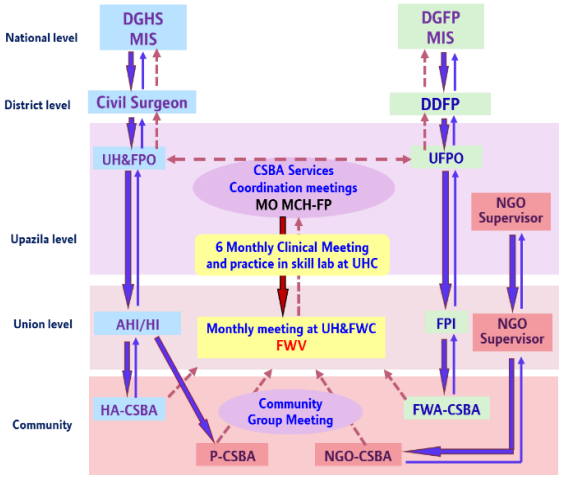


Figure 2: Supervisory and Reporting Framework for CSBA services

Note: Dotted line and arrow represents reporting on CSBA services) **Blue** represents DGHS in reporting hierarchy **Green** represents DGFP in reporting hierarchy

The CSBAs (all categories) used the standard reporting format provided by the MoH in order to capture essential data which could easily be integrated into the MIS of either directorate without duplication. Lalmonirhat district piloted the reporting model proposed in the CSBA supervisory and reporting system. All CSBAs were directed to maintain their own CSBA registers (log books) to note and record their services and some important vital statistics (such as number of deliveries, PNC conducted, newborn delivery dates to support birth registration). The channel of reporting was planned to follow the framework reflected in Figure 2.

As planned, each CSBA was supposed to prepare and sign her monthly report by the last day of the month using the reporting form. After completing the form, she would share the monthly report with

their field supervisor, who would review and countersign it. A copy of the completed report would be kept by the CSBA and the second copy would be submitted to the Union level clinical supervisor (FWV) during the monthly Union-level CSBA clinical performance review meeting. During the meeting the FWVs are supposed to review and discuss the reports received from CSBAs of their Union and validate or verify information/data received. FWVs then compiled all the reports into one report for the whole Union and signed it. The signed report was sent to Medical Officer Maternal Child Health Family Planning (MO-MCH FP) at the Upazila level for compilation. MO-MCH FP compiled all the reports received from all Unions through FWVs. H/she would then sent the compiled report to both UH&FPO and UFPO.

The MO MCH FP facilitated quarterly CSBA performance review meetings, where all members of the Upazila CSBA coordination committees participated. MO MCH FPs presented the reports and facilitated discussion at the Upazila quarterly CSBA meetings. After signing copies of these reports, the UH&FPO would submit the report to the Civil Surgeon and UFPO, who in turn submitted the report to Deputy Director Family Planning (DD-FP). The UH&FPO also submitted a copy of the report to concerned NGOs. The Civil Surgeon and DDFP then forwarded the report to MIS of DGHS and MIS of DGFP, respectively.

The supervision model was presented in a national stakeholder consultancy workshop held in June 2013. The model was updated to reflect the stakeholders' feedback and HRH project team proposed a joint endorsement by DGHS and DGFP for implementation in Lalmonirhat district and the model was piloted from April 2014 to February 2016.

Sub activity 513.2: Develop a detail implementation plan for one district including tools for monitoring and supervision for CSBAs

An implementation plan was prepared for the one pilot District (Lalmonirhat) and monitoring tools were developed and shared with DGHS and DGFP for review and approval.

The project oriented Health and Family Planning Officials from the other 16 Districts (132 Upazilas) as requested by DGHS. The orientation focused on CSBA supervision, monitoring, and reporting mechanisms for the project areas, excluding Lalmonirhat where the piloting took place. The orientations reached 525 Upazila and District level Health and Family Planning Officials (Male 446 and Female 79) as well as officials from central DGHS and DGFP. These orientations provided the project a platform which created access to CSBAs that facilitated the mobilization of CSBA reports and monitoring performances of public sector CSBAs. In February 2016, the project organized a workshop for the Civil Surgeons and Deputy Directors of Family Planning from the 17 HRH project-supported Districts with the participation of MoH senior officials, including Family Planning and Health Services directors to share project experiences and to advocate for the continuation of supports to the CSBAs. This workshop also emphasized CSBA performance monitoring and reporting that helped the project in mobilizing CSBA performance reports in Year 5. As a result of this mobilization, the reporting of CSBA performance increased throughout the project implementation period.

Sub activity 513.3: Approval letter from DGHS and DGFP for implementation in Lalmonirhat district

An approval letter from DGHS and DGFP was received in 2013 and the Directorates also issued formal official letters to the District Health and Family Planning departments for implementation of the Supervisory and Reporting system in Lalmonirhat district.

***Activity 514:** Provision of TA, logistical support and funding to hire additional supervisory staff as identified in needs assessment, to support the monitoring and supervision of CSBA trainees and graduates when they return to their communities.*

Sub activity 514.1: Orientation on Supervision & Reporting system at Union level

As part of the implementation of Supervision and Reporting system, the project organized orientation programs in 45 Unions of the Lalmonirhat District, and oriented a total of 438 project actors at various levels (165 male, 273 female). The participants included FWVs, CSBAs, and line supervisors of CSBAs from the government and NGOs. The orientation programs were organized and conducted by the partner NGOs, with support from the local Program Unit of Plan International Bangladesh, to orient the participants on the CSBA Supervisory and Reporting system as a whole. They included participatory discussions and clarifications on supportive supervision for CSBAs, key tiers, types of supervision, and the reporting system, including formats to be used at different levels of reporting. FWVs were assigned the responsibility of conducting supervision of and reporting on the clinical performances of CSBAs. In addition to the orientation, a number of refresher sessions were organized in 5 Upazila of Lalmonirhat District in 2015. A total of 237 CSBAs and 141 supervisors of CSBAs (48 female, 93 male) participated. After these orientations, the reporting system in the pilot areas improved and supervisors (FWVs) started performing their role not only as a supervisor, but also as a mentor.

Sub activity 514.2: Monthly CSBA Performance review and reporting meeting at UH&FWC Level

The monthly CSBA performance review and reporting meetings were organized at the UH&FWC level under the leadership of FWVs. From June 2014 to February 2016, a total of 1,035 monthly meetings were conducted in 45 unions (Aditmari – 8, Kaligonj – 8, Patgram – 8, Sadar – 9 and Hatibandha – 12) with an average of 275 CSBAs/session participating.

The meeting objectives were to present and discuss individual reports of each attending CSBA, which covered information on her day-to-day work (registration of pregnant mothers, ANC visits, referrals, PNC visits, and newborn care). These individual reports on CSBA's monthly performance were collected and reviewed by FWVs to facilitate discussion and/or further orientation on relevant issues, as deemed necessary. These reports were also consolidated for FWVs' reports, which provided information on the Union as a whole.

Sub activity 514.3: Quarterly CSBA Program Coordination committee meeting at Upazila level

A guideline for the quarterly CSBA program coordination committee meeting at the Upazila level was developed by the project in alignment with the approved CSBA supervision and reporting model. To develop this guideline, sharing and discussions were held with Upazila-level GOB line managers, NGO supervisors and the partner NGOs.

Quarterly CSBA program coordination committee meetings at the Upazila level were organized under the leadership of the UH&FPO in each Upazila, with the MO MCH-FP playing the role of the focal person. As part of the implementation, CSBA program coordination committees were formed in all five Upazila, and those committees met on a quarterly basis, with a total of 35 meetings to review CSBAs' activities and performance in their respective Upazila.

Sub activity 514.4: CSBAs Clinical performance review meeting at Upazila level

Some of the CSBAs who completed their training in the first semester of second year of the project, were not confident to conduct deliveries due to the limited awareness at the community level about the services provided by CSBA, therefore the Supervision and Reporting system conducted performance review meetings for CSBAs to assess the clinical skill (competency measurement) of CSBAs at the field level. The aim was to identify CSBAs performing poorly and provide the support to enhance their confidence to perform deliveries at home. CSBA clinical performance review meetings

were held bi-annually at the Upazila level under the leadership of MO MCH-FP, where UH&FPOs presented as the chair. A total of 3 rounds of sessions across the five Upazila of the District were held for one year from August 2014 to August 2015.

Sub activity 514.5: Skill lab for low performing CSBAs at FWC/UHC/MCWC/District Hospital

A total of 19 low performing government CSBAs, identified through CSBAs Clinical performance review meetings, completed their 15 day skill lab[11] at District Hospital and MCWC, Lalmonirhat in Year 3. The trainees, under the guidance of one technical person, were given the priority to undertake activities such as ANC, NVD, PNC and newborn care.

Sub activity 514.6: Document the piloting of CSBA supervision and reporting in a systematic way for capturing the lessons learned

An external consultant was hired to conduct the process documentation of the project piloted activities which included support supervision, BCC strategy and Gender Responsive Referral Linkages in Lalmonirhat district. The main objective of this process documentation was to compile implementation steps, lessons learned, challenges, and develop recommendations to help the MoHFW and other stakeholders make informed decisions about further expansion or redesigning of CSBA related activities. Moreover, the objective of process documentation was to learn from implementation experience, and use that knowledge to modify strategies and ultimately, policies of the project or organization. The process documentation was also expected to be used as a guideline for rolling out or replicating some or all of the piloted activities in future programs. Draft process documentation was shared with Plan International Canada, Cowater International, and Global Affairs Canada for their review and inputs before finalization.

The consultant recruited in 2015 used mixed methods approaches to capture the pilot activities , which included document desk reviews, in-depth interviews (with14 FWVs, 2 UH&FPOs, 2 UFPOs, 6 Partner NGO staff, and 6 HRH project staff of Plan International Bangladesh, both in field and Dhaka offices), focus group discussions (a total of 16 FGDs conducted, in which 84 participants were included, of which 59 were CSBAs and 25 were field staff of government line directorates), field visit and observation, as well as still photo-shooting methods.

With regards to the effectiveness of CSBA Supervision and Reporting activities, orientation training on CSBA Supervision and Reporting mechanisms improved the knowledge of the CSBAs line supervisors on how to perform their tasks skillfully. However, the orientation allowed a limited number of supervisors (HIs/AHIs, FPIs and FWVs) as most of the supervisors had multiple roles assigned to them and often prioritized work that had additional incentives. Monthly CSBA performance review and reporting meetings were held at the UH&FWC level under the leadership of FWVs these meeting moderately effective, as they also a vehicle to collect and review CSBA performance through submitted reports. Due to the limited number of FWVs at the UHFWC, FWVs were incapable of providing routine supervision of CSBA performance as anticipated during the project development stages. Instead, CSBA program coordination committees (PCCs) were formed in all five Upazila. The PCC, met on a quarterly basis to review CSBA activities, document challenges faced, and provide feedback. These meetings were held under the leadership of the UH&FPO. However, opportunities to conduct a CSBA performance review to identify challenges and provide feedback could not fully be leveraged due to the absence of a MO-MCH-FP (focal person of the committee). This position was vacant in four out of five Upazilas. CSBA clinical performance review meetings were held biannually at the Upazila level under the leadership of the MO MCH-FP/designated Medical Officer. The meetings were held more or less regularly, but were evidently less effective because of the limited

[11] The low performing private CSBAs were provided with skill enhancement training.

scope of clinical review at Upazila level. There was insufficient discussion around performance shortcomings and CSBAs were not provided with adequate opportunities to further develop their clinical performance through close follow-up and monitoring in the field. Skill labs were organized for 19 low performing CSBAs, as noted previously. These labs offered 15 days of skills development within the District hospital and MCWC in Lalmonirhat. Most trainees had the opportunity to conduct an average of 10 deliveries, 50 ANC check-ups and 40 PNC visits during the skill lab. However, the effectiveness of skill labs was found to be limited by the lack of functional EmOC facilities and services at District hospitals and in the MCWC.

Sub activity 514.7: Quarterly meeting with Statisticians of working Upazila for ensuring CSBA reports

OGSB was the lead in organizing and conducting quarterly meetings with Statisticians in the Upazilas of the 17 districts (to facilitate submission of CSBA reports); the meetings were held from 2015 to 2016. Upazila Health and District statisticians, Civil Surgeon and Deputy Director Family Planning (DDFP) facilitated the meetings which were conducted at the Civil Surgeon conference room.

Sub activity 514.8: Quarterly meeting with Private sector CSBAs

Plan International Bangladesh Program Unit supported the organization of the quarterly meetings for the private sector CSBAs. The meetings were held April to June 2016 and in June a total of 256 CSBAs participated. The aim of these meetings was to help to build a “bond “between Private CSBAs and discuss the issues for resolving problems they were facing at field level.

Workshops on CSBA supervision, monitoring and reporting -four CSBA coordination meetings were conducted during the project period; these coordination meetings provided the opportunity to arrange two national level workshops on CSBA Supervision, Monitoring and Reporting system. Senior officials from DGHS and DGFP at national level, civil surgeons and DDFP from 17 districts attended these two workshops. These workshops further strengthened the reporting system of CSBAs.

These workshops made the following recommendations to strengthen the CSBA program in these 17 Districts, which the DGFP and DGHS adapted in the districts following the workshops

- All meetings at District and Upazila level should include Maternal and Child Health as a fixed agenda item and CSBA activities, especially supervision, monitoring and reporting, should be discussed under the agenda.
- Respective Health and Family Planning Officials should be responsible for the supervision, monitoring and reporting of Private CSBAs within the government system.
- Civil Surgeon and DD - Family Planning should receive the monthly CSBA performance reports by the 5th of the following month to the Director PHC and Line Director – MNC&AH, DGHS. These 17 districts are copied on the report submitted to the Director (MCH Services) and Line Director (MCRAH), DGFP and to Project Manager - HRH Project, Plan International Bangladesh up to June 2016.
- DGHS should arrange quarterly coordination meetings with national level stakeholders.

Although CSBAs were available at the community level since 2004 when they were first trained by UNFPA, there was no specific register developed to record the activity of these CSBAs. Additionally, there was no structured reporting format developed to provide reports by CSBAs. However, recording of CSBA services and reporting on a regular basis are important parameters to measure CSBA performance. As part of the pilot intervention of CSBA supervision and Reporting System, the HRH project provided CSBA Registers and a reporting format in Lalmonirhat district. In addition, the reporting format was distributed among the CSBAs in the other 16 HRH districts. This had a great impact on improving CSBA reporting in these districts in comparison to other districts in Bangladesh.

This success was well noted by the government and in a CSBA coordination meeting in 2015, government officials requested the HRH project provide CSBA Registers and Reporting forms to all CSBAs in Bangladesh. Considering the importance of this request, the project decided to provide reporting formats and registers to all CSBAs in 17 HRH districts in the month of December 2016.

Learning and sharing workshop - Plan International Bangladesh organized learning and sharing Workshop on CSBA Program Implementation on 6 June 2016 in Dhaka. A total of 62 participants (24 female and 38 male) from the MoHFW, DGHS, DGFP, Development partners, INGO/NGOs, Training Institutions, local government and community representatives participated in the workshop.

It was recognized during the workshop that ultimate target of the government is to ensure institutional delivery, but most of the health facilities are not ready to provide this service. Additionally, there is a shortage of human resources, such as midwifes at facility level to perform duties. Therefore, deliveries at home by CSBAs are considered to be a transitional strategy of GoB. The GoB target is to provide training to 13,500 CSBAs by 2016. To support the government strategy, the HRH Project not only trained 1,665 participants as CSBAs, but also implemented interventions including CSBA performance reporting, monitoring and evaluation, and BCC activities in Lalmonirhat district. As this initiative brought about significant improvement in utilization of health services in Lalmonirhat, the workshop aimed to:

- Share the lessons and experiences of the interventions in Lalmonirhat to support the government plans and incorporate best practices in the sector.
- Review CSBA activities and performance to adopt the best learning for future programs.
- Provide guidelines and recommendations for utilization of the large number of CSBAs in the maternal and newborn health care services in Bangladesh.

Picture 3: UP Chairman of Modati Union sharing his experience on CSBA activity

The Civil Surgeon of Lalmonirhat district presented the key achievements, learning and recommendations from the CSBA program implementation in the district. The workshop appreciated the success of the Lalmonirhat program and the guests from Ministry and DGHS expressed their commitment to expand this learning throughout the country, considering **Lalmonirhat as a Model of CSBA programming**. The workshop made the following policy recommendations:

- Continue approach of using CSBAs as a transition strategy.
- Establish a coordination unit at central level with relevant stakeholders at Upazila and District level focal person to lead the CSBA Program. This was not possible as DGHS and DGFP indicated a limitation in the existing human resources, infrastructure and capacity within the Reproductive Health program, for the establishment the coordination unit.
- Provide practical training to CSBAs at Upazila and District facilities to improve skill sets after their basic training.
- Assign CSBAs in remote areas for home delivery and maintain linkage with respective UH&FWC.
- Envision a better assignment for CSBAs in the future greater health strategy.
- Ensure provision of incentives and rewards for financial sustainability of CSBAs.
- Provide regular logistic and other support and assistance.
- Commit to filling key positions crucial to augment CSBAs in reducing mortality rates.

- Ensure 24/7 EmONC facilities at District and Upazila level.
- Establish supervisory, monitoring and reporting system.
- Introduce a common register and reporting format.
- Prioritize selection of trained CSBAs in the 3 year Midwifery training course.

Output 520 – Strategic Activities

Activity 521: Conduct stakeholder consultations about constraints to using CSBAs at the community level

This activity was carried out by a consultant who conducted a stakeholder consultation needs assessment on the promotion of use of CSBA's at community level and developed a 5 year strategy for the HRH project.

Activity 522: Develop and update annual action plan for Behavioral Change Communication Program with MOHFW

Sub activity 522.1: Finalize the BCC strategy and action plan

A gender-sensitive BCC strategy and action plan was finalized by an external BCC consultant and the consultant submitted the final draft on BCC strategy, action plan and budget on May 22, 2013. The BCC activities incorporated a strategic approach including appropriate mixed messages, channels, and tools to inform, empower, and engage the target audiences with special focus on male engagement through printed materials like poster, calendars and through TfD shows, while keeping in mind accessibility at the community level.

Target audiences	Thematic areas for messages	Actionable steps	Recommended activities
Service recipients: - Pregnant women - Women of child bearing age	Maternal and infant deaths are preventable. As a pregnant woman you must know importance of: - recognizing danger signs during pregnancy, childbirth, and the postpartum period; - birth preparedness; and - Newborn care within 28 days.	Get examined by a CSBA in your community early in the pregnancy, and at least 4 times during pregnancy, and within 48 –72 hours after childbirth so required actions can be taken to enable you and your baby to stay healthy.	House-to-house Interpersonal communication PC with pregnant women. Drama (TfD) shows.
Influencers: - Mothers/ in-laws - Husbands - CGs - LGIs - TTBAs - FLHCPs	Maternal and infant deaths are preventable. Promoting healthy babies and mothers is a family and community responsibility. There are actions we can all take to help prevent the deaths of pregnant women and babies.	Get your wife or daughter-in-law or the pregnant woman in your community examined by a CSBA early in her pregnancy, and at least 4 times during pregnancy, and within 48 – 72 hours after childbirth so that actions can be taken to enable her and the baby to stay healthy.	Introductory meeting at Union Parishad and Upazila Parishad; TfD shows; posters; flyers/leaflets; and calendars

The BCC activities were implemented in three Upazilas of Lalmonirhat district (Patgram, Hatibandha and Kaligonj) based on the project's BCC strategy and the action plan for the piloting period starting from Year 3 Q1. Separate guidelines for implementation of each intervention were developed and staff members were oriented through trainings by the partner NGOs, in collaboration with HRH project staff from Plan International Bangladesh. The roles and responsibilities of the implementing partners and stakeholders in implementation of the BCC strategy were as follows:

- In collaboration with the Ministry of Health and Family Welfare at the District and Upazila-level and partner NGOs, Plan International Bangladesh took the lead role and provided funding support through the project budget to implement the BCC action plan in its working areas.
- One member of the project team from Plan International Bangladesh Country Office (BCO) coordinated and monitored the BCC with GoB counterparts (DGHS and DGFP) at national, District and local levels. In collaboration with Plan International Bangladesh's Lalmonirhat Program Unit (PU), the person also provided technical support to the partner NGOs as required.
- At the local level, the PU of Plan International Bangladesh was responsible for coordinating with the MOHFW and partner to implement BCC activities in the poor-performing areas, based on evidence available from a local level KAP (baseline) survey conducted by the project. The PU was also responsible for monitoring progress and submitting monthly/quarterly reports to the project management.

To support BCC activities, as outlined in the strategy document, the partner NGOs were primarily responsible for:

- Participating in an orientation workshop on the BCC action plan to ensure understanding of the conceptual framework (including its gender equality integration), pursue the same strategic goals, and apply relevant technical skills;
- Implementing the BCC action plan in consultation with the PU, MOHFW representatives and HRH project team;
- Closely coordinating and monitoring the progress of BCC activities, development, testing, printing, dissemination, and technical assistance at the community level; and
- Promoting the utilization of CSBA services by working with the local level authorities, Civil Surgeons, LGI representatives and community leaders to activate/strengthen local committees such as Upazila Health Advisory Committee, Union Health & Family Welfare Centre Committee, Union Education, Health and Family Planning Standing Committees, and community groups at CC.

Sub activity 522.2: Sharing the BCC plan with national counterpart (DGHS, Health Education Bureau)

The BCC materials, including posters, two types of stickers, desk, wall calendars, sign boards for Private CSBAs, and message boards developed under the project were shared with the IEC Technical committee of Ministry of Health and Family Welfare (MoHFW) after conducting the field test of these materials. The sharing was held on March 2014 and the IEC Technical committee approved these materials. Examples of printed BCC materials are included in Annex 6.

Activity 523: Provide technical assistance and logistical support to MOHFW in implementing the Behavioral Change Communication Program at the community level to promote the use of CSBAs

523.1 Conduct a follow-up mini KAP survey to evaluate pilot BCC interventions for replication planning

Baselines KAP survey - A baseline knowledge, attitude and practices (KAP) survey was conducted by an external consultant who submitted the final baseline report of the KAP in October 2013. The overall objective of this survey was to understand the KAP of women, who either had a live birth within 5 years preceding the survey (recently delivered women) or were currently pregnant, using maternal and child health services.

Knowledge of recently delivered women and currently pregnant women using ANC, PNC, delivery and neonatal care was found to be low. Focus group discussions[12] conducted showed that a large majority of community members were unaware of services provided by CSBAs for pregnant women and women with newborn babies. A number of community group members and most frontline health workers were aware of CSBAs and their activities. Major barriers for utilization of CSBAs for MNH services were: presence of other community health workers such as those supported by BRAC, RDRS and other NGOs, who provide services without fees, as well as lack of awareness of gatekeepers (mothers in law, husbands, community and religious leaders, etc.) about CSBAs and their activities. Therefore, the survey strongly recommended BCC and other promotional activities for CSBAs to promote their utilization in the community to contribute to the prevention of maternal and newborn death.

Endline KAP survey - the endline KAP survey was conducted by another external consultant and the report was finalized in November 2015. The endline KAP survey was conducted when the project interventions were at the final stage. The comparison between the endline KAP survey data and baseline data suggests that the project made a positive contribution towards the broad goal of HPNSDP, which is ensuring quality and equitable health care for all citizens by improving access to and utilization of health, population and nutrition services, and towards the more specific goal of promoting CSBA services at community level.

The endline data showed that the situation positively improved from the baseline in terms of major indicators. For example[13], in the endline, 82.1% service recipients had heard about CSBAs, 98.5% knew of the presence of CSBAs in the union and 95.9% knew the responsibilities of CSBAs. These indicators were 23.5%, 21.3% and 24.5% respectively in the baseline survey. The endline survey also revealed that 45.3% received ANC, 50.3% received PNC and 70.5% received NVD services from CSBAs. These indicators were 1.3%, 1.8% and 6.2%, respectively at baseline. The following graphs represent a comparison of key KAP indicators between baseline and endline of piloting areas of Lalmonirhat district.

[12] FGDs were conducted with mothers and mother-in laws, husbands, TBAs, in each Upazila

[13] Please note these percentages are not available by sex so cannot be disaggregated

Table 6: MNH: KAP survey indicators between baseline and endline of piloting areas of Lalmonirhat district among currently pregnant women and recently delivered women

Baseline	(%)	Endline	(%)
Currently pregnant women		**Currently pregnant women**	
Received any ANC by skilled provider	64.4	Received any ANC by skilled provider	90.2
Received ANC by CSBAs	3.3	Received ANC by CSBAs	56.5
Received 4 or more ANC by skilled provider	29.5	Received 4 or more ANC by skilled provider	25.7
Recently delivered women		**Recently delivered women**	
Received any ANC by skilled provider	72.4	Received any ANC by skilled provider:	96.6
Received ANC by CSBAs	1.3	Received ANC by CSBAs	45.3
Received 4 or more ANC by skilled provider	45.1	Received 4 or more ANC by skilled provider	72.3
Recently delivered women	15.7	**Recently delivered women**	29.5
Place of delivery: Hospital/Clinic	6.2	Place of delivery: Hospital/Clinic	70.5
Place of delivery: Home by skilled provider (CSBA)	1.8	Place of delivery: Home by skilled provider (CSBA)	41.6
Received any PNC by skilled provider:	23.4	Received any PNC by skilled provider	54.6
Received PNC by CSBA	1.8	Received PNC by CSBA	50.3
Received PNC by skilled provider within 48 hours	4.1	Received PNC by skilled provider within 48 hours	19.3
Currently pregnant women		**Currently pregnant women**	
CSBA present in Union	21.3	CSBA present in Union	95.7
CSBA's responsibility	71.5	CSBA's responsibility	93.5
Recently delivered women		**Recently delivered women**	
CSBA present in Union	21.3	CSBA present in Union	98.5
CSBA's responsibility	24.6	CSBA's responsibility	95.9
Currently pregnant women (Knowledge)		**Currently pregnant women (Knowledge)**	
Knows about the no. of ANC required	29.0	Knows about the no. of ANC required	84.7
Knows about PNC within 48 hours	17.7	Knows about PNC within 48 hours	45.1
Recently delivered women (Awareness)		**Recently delivered women (Awareness)**	
Aware of no. of ANC	22.7	Aware of no. of ANC	99.5
Aware of PNC within 48 hours	13.3	Aware of PNC within 48 hours	90.4

Sub-activity 523.2: Develop recommended BCC tools, materials and provide appropriate training for implementation of BCC pilot in one district

As per the BCC strategy document, the BCC activities were meant to incorporate an appropriate mix of messages, channels, and tools to inform, empower, and engage the target audiences, while keeping in mind accessibility at the community level. As per guidelines, several BCC tools were developed and utilized at the community level to promote the utilization of CSBA services in the

community. IEC materials included message boards, CSBA sign-boards, posters, stickers (two kinds), and calendars (both desk and wall). A consultant was hired to develop these materials; the project team decided the types of materials to be developed for BCC purposes. The materials were distributed mostly through private CSBAs and partner NGO staff with the help of the CGs and CSGs. Approaches used for material dissemination were:

- **Message boards** were installed in front of the CCs, UH&FWCs, and UHCs and UP offices, targeting the local communities as potential audiences.
- **Sign boards** displaying CSBA information were installed at CSBAs' houses.
- **Posters** were distributed and hung in public places such as tea stalls, village shops, road corners, schools, UH&FWCs, CCs and households to target local communities, particularly potential recipients of CSBA services, as well as influencers (mothers, in-laws, husbands, community leaders) and/or family and community level decision makers related to health care seeking.
- **Stickers** were distributed and found pasted on walls and main doors of households, targeting specifically the women (particularly pregnant mothers and influencers) and men associated with health-related decision making.
- **Wall calendars** were distributed at household and institutions (education and health) levels.
- **Desk calendars** were distributed mainly at MOH&FW office levels, targeting local health service providers and recipients.

600,000 stickers, 30,000 posters, 14,000 Wall Calendars, and 200 Desk Calendars were printed and 119 message boards and 76 sign-boards for private CSBAs were installed.

Picture 4: A sign board is displayed with CSBA information

Picture 5: A CSBA Calendar displayed at a village shop

Sub activity 523.3: Implement BCC activities at three Upazila of Lalmonirhat District

Table 7: Population Statistics in Lalmonirhat District

Upazila	# Unions	# Villages	Total Population	# Pregnant women	# Women of child bearing age	# children under 1Y	# children under 5Y
Hatibandha	12	62	300,000	1,364	64,870	4,887	18,126
Kaliganj	8	32	200,000	1,765	62,420	6,550	37,629
Patgram	8	28	200,000	1,778	44,107	5,750	26,256
Total	28	122	700,000	4,907	171,397	17,187	82,011

Interventions related to the BCC strategy were piloted in three of the five Upazila in Lalmonirhat District. The detailed number of Unions, villages and populations in three Upazila where BCC activities were piloted, are as below:

Source: Plan International Bangladesh, Lalmonirhat Program Unit

523.3.1: CSBA introduction sessions at Upazila level

5 introduction sessions were organized at Upazila levels with participants from the MoHFW line departments, Local Government representatives, NGOs and CSOs to introduce newly graduated private CSBAs and to inform participants about the HRH project objectives, implementing strategies, and the roles of CSBAs at the community level. The introduction was also an opportunity to seek back-up support for referral or related emergencies and for private CBSAs to position themselves within the community and to help the community members and leadership understood the role, responsibilities mandate of the CSBAs, given that public sector CSBAs were well known to the community as a health care provider.

This intervention was carried out adhering to guidelines developed by the partner NGOs in consultation with MoHFW and support from the project staff. An orientation program was organized for the partner NGOs' and Plan International Bangladesh field staff on the implementation process and steps. The introduction of newly graduated CSBAs was done through several meetings organized in Kaliganj and Patgram Upazila, by implementing partners (Plan International Bangladesh and ESDO for the respective government health and family planning supervisors, managers and UP representatives). The meetings were also attended by the local UFPO, MO-MCH, UH&FPO, RMO and other senior staff nurses.

Picture 6: CSBA introduction sessions at Upazila level

The HRH trained CSBAs were formally introduced at the Upazila level during the pilot period. These introductory meetings offered CSBAs a valuable opportunity to introduce themselves at the community and Upazila level. These sessions informed the community members (men and women) about the presence of CSBAs in the community. UP representatives attended the Upazila level meetings to familiarize themselves with CSBAs and the services being provided in the local communities.

523.3.2: Conduct Theatre for Development (TfD) sessions

TfD was used in the piloting of the BCC strategy. Before conducting TfD shows, TfD groups were formed from the respective piloting areas, which were Kaliganj, Patgram and Hatibandha Upazila. Two batches of ToTs were organized with the representatives of these groups. All TfD groups were also trained on TfD with the co-facilitation of the members of these groups who received ToT. A professional group (consultant) provided these ToTs and Training for TFDs. Finalizing the TFD session information script required a meeting with locally identified TfD groups at Patgram and Kaliganj Upazila Health Complexes, and with the local partner project office in Hatibandha. A total of 10 TfD Groups were formed in Hatibandha, Patgram and Kaliganj Upazila, consisting of 150 (70 male and 80 female) members, among which 40 members from 10 TfD groups were selected and provided with ToT in order to train the remaining TfD group members (110 people). A total 1,996 TfD shows were performed at the village/community level in Hatibandha, Kaliganj and Patgram Upazila by the trained TfD groups; these shows were organized by ESDO with the help of local UPs, CSBAs, CG and CSG members. As a project phase out strategy, of the 10 TfD, only three groups continued to perform until the end of 2015. TfD shows reached approximately 200,000 community members (40,000 male, 100,000 female and 60,000 adolescents) in the three piloting Upazila and were one of the successful BCC activities given their “edutainment” value and the large crowds they drew in communities.

TfD shows were interactive, using popular folk-based media (Harmonium, Tobla Dugi, Dhol etc.) and performed by specialized (trained and organized) groups of local activists. The shows mainly targeted community groups and influencers (both women and men), but participation of other community members such as children, adolescents, the elderly, and people from neighbouring communities was also encouraged. On average, about 200 males, females and adolescents observed each show. These shows addressed the local issues related to pregnancy, delivery, newborn care and the importance of receiving services from CSBAs for maternal and newborn health care. These shows incorporated gender equality issues, including the (limited) voice of women, especially for their health rights, by depicting the participation of women in decision making for health services. Women, in particular, were made aware of the importance of ANC, PNC and skilled delivery services. By presenting well thought out drama characters, especially of men acting positively towards women’s reproductive rights, the TfD may have contributed to increasing men’s’ positive attitudes towards pregnant women.

523.3.3: Union level fairs

A fair, which is an annual gathering of village people, is a traditional occasion in Bangladesh, which functions as entertainment while circulating critical health information and services. This fair can be a vehicle to disseminate important messages among men, women and adolescent girls and boys in communities to bring positive changes in their

Picture 7: A TfD show in Lalmonirhat District

daily practices. The HRH project utilized this concept and as part of BCC activity, the project organized “Union level Fairs” or “Bou-Sasuri Mela” (daughter-in-law and mother-in-law fairs) in 28 Unions of 3 Upazila of Lalmonirhat District (Kaligonj, Hatibandha and Patgram Upazila) from 3-23 March 2015. The aim of these fairs was to promote CSBA services at the community level, to raise the voice of daughter in laws in making decisions about her own and her child’s health, and to bring positive changes among the influencers, especially in mothers in law of the family regarding maternal and neonatal health.

Picture 8: Stall in Union Level Fair

The schedule of each of the fairs included discussions on safe motherhood, TfD shows, a quiz competition and an award ceremony. In the fair, different stalls were established including health, family planning by MOH supported by CSBAs NGOs, blood grouping, Union information and service centre, CSBAs, and sanitation. These stalls displayed their own activities and disseminated the information to all visitors. The fair promoted learning and self-realization, and encouraged participants to seek appropriate health care services, especially from CSBAs, but was not as effective as the TfD and IEC materials due to limited opportunities for influencers to participate in fairs. The quiz competitions among the mother in laws demonstrated their knowledge on standard MNCH services and practices in case of emergency. The TfD shows held in these fairs first portrayed traditional hierarchical relationships between ‘daughter-in-law and mother-in-law’ and then showed how mothers-in-law can be instrumental in dealing with issues related to maternal and neonatal health. Pregnant mothers had the opportunity to receive free ANC and blood group testing at the fairs. Community members were able to learn about the benefits of using CSBA services and to meet the CSBAs in their communities. Women and men also learned about family planning methods at the fairs. The fairs presented opportunities for interaction and developed mutual trust and respect between CSBAs and community members.

The CGs and Union Parishad contributed in mobilizing communities and other supports (selection of venue, security, refreshment, decoration, etc.) to make the fairs more engaging. In addition to the general population, the Upazila Chairman, Upazila Nirbahi Officer (UNO), Deputy Director - Family Planning (DD-FP), Upazila Health and Family Planning Officer (UH&FPO), Upazila Family Planning Officer (UFPO), Medical Officer (MO), different levels of local leaders, teachers, Community Group (CG), and Community Support Group (CSG) members also participated in the fairs and presented awards to the best CSBA, model mother and ideal mother-in-law in the union. The award presentation ceremony had a huge impact among the CSBAs and family members. CSBAs were encouraged to work proactively to be recognized for their work and family members, and especially Sasuri (mother-in-law), became aware of their roles to help ensure the health of future generations and promote decision-making of their daughter-in-law. These activities were intended to break the traditional, misleading, and stereotypical practices and beliefs around ANC, skilled delivery and PNC, and presented the importance of ANC and PNC and selecting a CSBA for normal deliveries.

These fairs had a considerable impact among the general population and almost 70,000 women, men and adolescents attended. The fairs contributed in changing attitudes of family members, especially mothers-in-law, towards MNCH services which were well reflected in the endline survey of the project. The report showed that almost 97.8% of the currently pregnant women wanted ANC services by the CSBAs and 97% of this same group wanted delivery services from CSBAs.

Sub activity 523.4: Document the piloting of BCC interventions in a systematic way for capturing lessons learned

An external consultant was hired in August 2015 to conduct the process documentation of the project activities in establishing the BCC strategy in Lalmonirhat district. The consultant responsibilities included document desk reviews, key informant interviews; focus group discussions, field visits and observation, as well as still photo-shooting methods The BCC strategy had two distinct objectives to achieve. The first one was to raise awareness among service recipients on the existence and benefits of CSBA services, the process documentation was also expected to be used as a guideline for rolling out or replicating the BCC strategy developed in future programs. Draft process documentation was shared with Plan International Canada, Cowater International and Global Affairs Canada for their review and inputs before finalization.

Regarding the effectiveness of BCC interventions, the primary sources of qualitative data suggest that Union level fairs and TfD shows were highly effective and IEC materials were to some extent effective in raising awareness at the Union level. However, TfD and IEC materials were more effective than Union fairs in raising awareness among influencer groups at the house hold and community level. This variation in effectiveness may have resulted from the limited opportunities for influencers, such as husbands, to participate in fairs due to other engagements, and the inability of women of reproductive age to read printed IEC materials due to illiteracy.

Round Table discussion on CSBA activities at National Level

This activity was not implemented and instead was replaced with a learning and sharing workshop that was organized and which has been described earlier in this report.

Output 530 – Strategic Activities

Activity 531: With UNFPA, BNC, CSBA training centers and other stakeholders, assess existing referral system and identify gaps and the resources needed to address them.

This activity was carried out by a consultant who consulted communities and other stakeholders such as MOH and made recommendations on the development of referral linkages for institutional deliveries.

Activity 532: With stakeholders, develop, and update as necessary, a gender sensitive plan for an improved referral linkage system

Sub-activity 532.1: Develop/adopt a piloting plan for improved referral system in the selected district

Baseline information showed that a functional CSBA referral system from community to health facilities for normal deliveries and/or obstetric emergencies practically did not exist. Therefore, the project developed a plan to improve the referral system in Lalmonirhat district and the model was piloted from April 2013 to March 2015.

Sub-activity 532.2: Share the piloting plan with the stakeholders at district level

The plan for an improved referral system in Lalmonirhat district was shared with the Civil Surgeon and DDFP at the District level and also with the Service providers at UHC in February 2014.

Activity 533: In collaboration with UNFPA, BNC, CSBA training centers and other stakeholders, provide TA to support a referral system between CSBAs and the institutions that address maternal & newborn complications in their communities.

One of the contributing factors to high maternal mortality in Bangladesh is the delay in accessing emergency obstetric-care (EmOC) facilities. These delays have been well-described as existing at three levels: first-delay in making decision to seek care, second-delay in arrival at a health facility, and third-delay in getting adequate treatment. These three delays need to be addressed and a GRRL system can prevent these delays.

Based on the approved PIP, a model of functional referral linkage between CSBAs at community level and facilities with EmONC services was piloted in three Upazila (Kaliganj, Patgram and Hatibandha) of Lalmonirhat District. This was managed by Plan International Bangladesh and implemented through the project partner, ESDO.

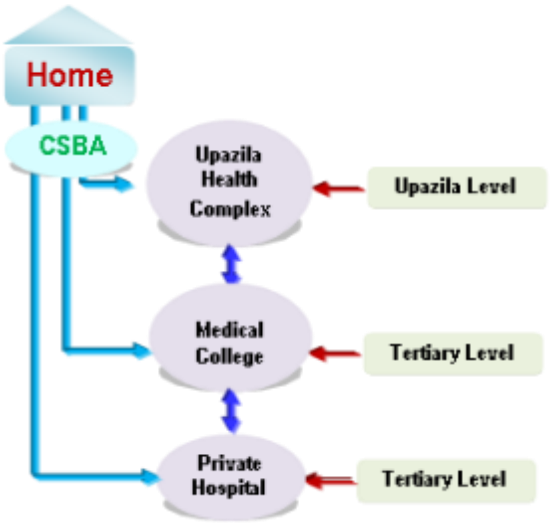


Figure 3: Referral Model for Lalmonirhat District

Sub-activity 533.1: Train selected CGs and CSBAs to develop gender sensitive referral linkages for maternal & newborn complications

Engaging CG members for determining and identifying priorities and actions for referral activities is crucial to make referral linkage successful. They have the potential to play a role at the community level for effective referral and also influence the families who are unwilling to go to a facility in emergencies and encourage women on decision making and men in getting involved. Therefore, a module on GRRL was developed, with support from Cowater International and Plan International Canada, to provide training to CGs in piloting areas. A total of 60 CG groups were trained with the objectives to raise awareness of CG members on the impact of gender based discrimination and barriers on maternal and child health; on referral systems/protocols; and on promoting roles of CGs in strengthening referral systems. The project also organized 60 refresher training sessions on GRRL for 60 CGs in Year 3. A total of 958 (273 female, 685 male) CG members participated in these refresher trainings. The training focused on danger signs, both of mothers and children, signs and symptoms requiring immediate referral and where the referral health facilities were located. The trained CG members supported the HRH project to conduct the Participatory Wealth Ranking (PWR) process to identify the poorest families within their communities. They were also sensitized on how to support GRRL through family and community mobilization. The CGs and CSGs in the communities initiated a drive to mobilize funds and were able to collect a total of USD 160,000, which was complemented by the local government's contribution of approximately USD 130,000. A portion of these funds was allocated to referral support for the most disadvantaged pregnant women in emergency cases. The CGs and CSGs also provided transportation and financial support for poor referral patients when needed. Additionally, CGs and CSGs mobilized local resources and in collaboration with Union Parishad, they established 54 Birthing Place/Delivery Rooms, 82 Breast Feeding Corners and 95 Patient Waiting Rooms in community clinics in Lalmonirhat district.

Picture 9 Patient Waiting Room Supported by CG

Sub activity 533.2: Train 80 CSBAs on Gender Responsive Referral Linkages for maternal and new-born complications

A draft guideline in English on GRRL for new CSBAs was developed by Plan International Bangladesh, with technical support from the consortium led by Cowater International. These training guidelines were translated into Bangla. The objectives of the training program were to raise CSBAs' awareness of: a) the impact of gender based discrimination and barriers on maternal and child health, b) the referral system/protocol, and c) their role in strengthening the referral system. Similar to the training for CGs, before providing training to the CSBAs, partner NGOs staff was oriented on the course outline. Then trainings for CSBAs on Gender Responsive Referral Linkages were organized and conducted by the partner NGO.

4 batches of training on GRRL were organized for the CSBAs during Year 3. A total of 85 CSBAs participated in this training from Kaligonj, Patgram and Hatibandha, on the impact of gender based discrimination and barriers on maternal and child health, referral systems/protocols, and the roles of CSBAs in strengthening the referral system (note: sometimes CSBAs even accompanied the referred patients to ensure better support at the facility). The CSBAs were also sensitized on gender concepts; gender discrimination in health services; referral steps; when and how to refer; gender issues to consider during referral; and how to ensure a gender sensitive environment in the health facility or home during delivery.

Sub-activity 533.3: Sensitize service providers at referral centres for establishing functional referral linkages for CSBAs

During the needs assessment for the HRH project, some CSBAs complained that often cases referred by them to UH&FWCs, UHCs or District Hospitals do not receive required services, which tarnish their image and diminishes their credibility in the community. Therefore, to help address the communication gap between CSBAs and health personnel at referral centres, namely UHCs, MCWCs and District Hospitals in Lalmonirhat district, several meetings and workshops were carried out to sensitize them with regards to establishment and maintenance of functional referral linkages.

3 workshops were organized at the District level with the participation of Civil and other senior MoH officials from District Hospital, MCWC and UHCs to strengthen the referral mechanism between CSBAs and the service providers at facility level. The workshop resulted in the agreement to develop a referral flyer which shows the appropriate referral centres for mothers and newborns with complications within Lalmonirhat District.

These workshops provided a platform to discuss and analyse the referral scenarios and challenges of the district and Upazila levels, especially between CSBAs and service providers at District/Upazila Health facilities. A number of important decisions related to the referral system were made. For example, a separate referral slip was introduced for CSBAs to identify the cases they referred, and a mechanism for documenting CSBA referrals at UHCs, the MCWC and the DH was established. Additionally, all health facilities providing EmONC services at the Upazila and District level under this project initiated dedicated referral registers in emergency/labour rooms, which were used to keep medical and administrative records of the patients referred by CSBAs.

Sub activity 533.4: Quarterly meeting with UP Education, Health and Family Planning standing committee to functionalize Gender Responsive Referral Linkages for maternal and newborn complications

There are different committees for overseeing population services, including health services, at the Union and Upazila level. Two such committees are “Upazila Hospital Management Committees” at Upazila level and “Union Education, Health and Family Planning Standing Committees” at Union level. These two committees were non-functional at the start of the project, but the project strengthened these committees to support the piloting of GRRL for maternal and newborn complications. All Union Education, Health and Family Planning Standing Committees were strengthened through quarterly meetings with 16 of the committees, with a total of 317 meetings held during the project period. In each of the meetings, the committees reviewed the overall progress of implementation, and the required supports to CSBAs and CGs to determine where their support was critical.

For example, UP-SCs discussed CSBA issues and how to create working opportunities for CSBAs in local communities, and addressed the problems between CSBAs and local health facilities. The UP-SCs lobbied the UP chairmen to allocate funds to improve service delivery in the CCs and UH&FWCs, and took measures to create spaces within CCs to conduct deliveries, thereby establishing an enabling environment for CSBAs to conduct safe deliveries. The SCs were involved in nominating local eligible CSBAs from poor families to receive Vulnerable Group Development cards to promote CSBA services at the community level. These actions contributed to key referral objectives such as: a) encouraging relevant stakeholders to support and make referral effective; and b) providing support to poor families.

Sub-activity 533.4: Provide cell phones to CSBAs and link them to focal persons (FWVs, Nurse-midwives, MOs, Gyn. and Obs. consultant) at selected referral facilities.

76 HRH-trained private CSBAs in three Upazila were provided with cell phones (Nokia Company; Model: X2-02). These phones were distributed among these CSBAs to establish a link with the focal persons at selected referral facilities such as UHCs, MCWCs, and District Hospital.

Picture 10: CSBA supplies and CSBAs from Gazipur were receiving CSBA Supplies

In addition to cell phones, delivery kits were provided to CSBAs twice during the project period. 300 units of CSBA Delivery Kits[14] were distributed in April 2015 and 350 units in December 2016. Most CSBAs trained under the HRH project were working in the community on a voluntary basis. During the project design it was assumed that private CSBAs could earn money by providing CSBA services in the community. However, the assumption was not accurate and most CSBAs were providing services for free and providing the supplies to continue their service provision. Supplying of pregnancy test strips was an additional and innovative idea as the private CSBAs could charge a minimal fee to conduct the pregnancy test and in that process link them with a potential future client.

Picture 11: One of the CSBAs from Dinajpur was receiving CSBA Supplies

[14] Provided supplies of 35 Pairs of Surgical Gloves, 36 pieces of Cord Clamp, two pots of Bleaching Powder (each pot contains 500 gm. of powder), one box of pregnancy stripes (50 pregnancy stripes) and one weight scale machine.

Sub activity 533.5: Referral center visit- Introducing CSBAs to the Referral centers

As planned, a total of 4 Referral center visits were completed during the pilot period to introduce CSBAs to the referral centers at District level (District Hospital and MCWC) and with the service providers (CS, DDFP, RMO and other health staffs). A total of 114 Public and Private CSBAs visited the referral center and met with the service providers, and discussed the best modalities to ensure timely referral and appropriate supports for the referred patients. These visits improved CSBA's knowledge of referral centers and services, and opened up essential communication between CSBAs and service providers at higher level facilities.

Sub-activity 533.5: Conduct participatory wealth ranking (PWR) for provision of safety net support to the poor (C, D and E wealth categories) for referral

The HRH project provided safety net supports to the poor and hardcore poor households who had been referred from the community to higher health facilities to receive treatment for maternal and newborn complications. Before providing the safety net support, the HRH team conducted a PWR in Kaliganj and Patgram Upazila of Lalmonirhat district. The PWR process helped the project to categorize the households as per their economic condition: rich to hardcore poor (Category A – Well off; Category B – Middle; Category C – Upper poor; Category D – Poor and Category E – Extreme poor). CGs, CSGs, as well as adolescents in the respective community, actively participated in the PWR process which followed the guidelines of Plan International Bangladesh. The total duration of the PWR process was three months (April-June 2013); detailed information is available in tabulated format. The project provided the following safety net supports to the households that fell under C, D and E categories:

- **Transport support:** Patient's transport cost from home to referral center (cost related to Van/Rickshaw fare, Bus/Micro bus fare, Ambulance fare, etc.)
- **Medication:** All costs related to purchase of medicines to manage the referred patients (both pregnant mother and newborn)
- **Consultation fees:** Consultation fees of doctors if patient was referred by CSBAs
- **Hospitalization cost:** Surgery cost, accommodation cost and food cost at referral center.

Those selected from various categories were eligible to receive all or partial support mentioned, dependent on necessity and economic condition of the family. The referrals that were made by HRH trained CSBAs were accounted for by the safety net support and Plan International Bangladesh, the Partner ESDO, and community representative from CG jointly took the decision of providing partial or full support after evaluating the needs of the households. During the pilot period, the following centers were used as referral centers:

1. Kaliganj Upazila Health Complex
2. Hatibandha Upazila Health Complex
3. Patgram Upazila Health Complex
4. Lalmonirhat District Hospital
5. Rangpur Medical College and Hospital
6. Private Clinics/Hospital (if applicable)

Out of 900 pregnant mothers and 162 newborn referrals (113 male children and 49 female children), 15 families were provided with safety net support (amounts ranging from BDT 1000 – 8000) by the project during its pilot. Apart from this, many poor patients were referred to higher level health facilities with financial support from the CGs and UPs. This safety net support from the project facilitated access to care for the targeted the community members requiring support as determined by the community and UP management groups.

Table 8: Participatory Wealth Ranking (PWR) in Kaliganj and Patgram

Name of Upazila	Name of union	# of household	Population under each Wealth Ranking category				
		Total HHs	A	B	C	D	E
Kaliganj	Votmari	5,799	75	636	1,731	2,168	1,189
	Modati	7,452	205	1,909	36,941	1,380	264
	Tushvander	7,892	240	1,219	2,713	3,147	573
	Dalagram	5,529	77	181	2,272	2,938	61
	Chandrapur	7,468	256	1,070	2,204	3,157	781
	Gorol	4,978	100	487	1,683	2,379	329
	Chalbala	6,013	466	1,203	2,092	1,466	786
	Kakina	4,972	51	317	1,812	2,468	324
Sub total		*50,103*	*1,470*	*7,022*	*18,201*	*19,103*	*4,307*
Patgram	Sreerampur	5,560	640	814	1,663	2,172	271
	Patgram	5,128	344	833	1,563	1,914	474
	Zogatbar	5,333	414	835	1,719	1,614	751
	Kuchlibari	4,061	281	580	1,947	849	387
	Zongra	4,535	362	854	1,220	1,319	780
	Bauora	5,457	462	1,046	2,099	1,185	665
	Dhahagram	1,294	140	364	370	272	148
	Burimari	3,299	300	554	894	972	579
Sub total		*34,667*	*2,943*	*5,880*	*1,475*	*10,297*	*4,055*
Total		**84,770**	**4,413**	**12,902**	**29,676**	**29,400**	**8,362**

Sub-activity 533.6: Process documentation of the gender-responsive referral linkages system

As explained under output 523.4 the process documentation of the piloted activities was implemented in Lalmonirhat district in order to establish GRRL system. The main objective of this process documentation was to compile implementation steps, lessons learned, challenges, and develop recommendations to help the MoHFW and other stakeholders make informed decisions about further expansion or redesigning of activities.

Regarding the effectiveness of the GRRL interventions: the training programs for CG members and CSBAs were effective for orientation on the referral systems and gender responsiveness of the services. The training also enabled them to better understand the gender-related barriers women face in decision-making, which result in the first and second delays in accessing timely care. The subsequent organization of coordination meetings among CGs, CSGs and CSBAs were effective in creating synergy in community willingness to mobilize resources locally and encourage relevant stakeholders to raise and utilize funds to develop referral facilities and the CC. Through effective utilization of the locally mobilized resources, private breast feeding corners, separate patient waiting rooms for men and women, and labor rooms were established in many CCs. 15 families out of 900 pregnant mothers and 149 newborn referrals, were provided with safety net support to access referral health services.

Referral center visits improved CSBAs' knowledge of referral centers and services and opened up essential communication between CSBAs and service providers at higher level facilities. The workshop held for the service providers' at the District level was effective in reviewing the overall referral situation of the District; developing a plan to agree on a referral mechanism between CSBAs and referral centers; and identifying the support the CSBAs requires to successfully refer mothers or

newborns with complications. However, the interventions were not effective in ensuring that patients referred to the secondary and tertiary hospitals were receiving timely, sufficient and quality services, because there was limited focus on improving facilities and services within the government-led referral centers.

2.2 Close out Activities

2.2.1 Inventory of Assets and Handover Procedures

During the project period, several assets and supplies (list is provided in tabulated form) were procured by partner organizations, valued at BDT 2,102,001 or CAD 28,410.

All the assets were recorded in the asset register of each partner organization. At the end of the project, partner organizations were asked to provide the updated condition of the listed assets and supplies. They were also asked to provide a plan on how they were going to utilize these materials after ending of the project. OGSB, LAMB and Kumudini Hospital proposed that they would utilize these materials for upcoming training of CSBAs or similar trainings of health care providers.

The proposal was reviewed by Plan International Bangladesh management and was sent to Global Affairs Canada through Plan International Canada and Cowater International for approval. After receiving approval from Global Affairs Canada, the materials and supplies were handed over to partner organizations for their utilization as per proposed plan. However, one laptop of ESDO was handed over to Bogra Nursing Institute so that this institute could utilize it for academic purposes. Musical instruments for TfD shows were handed over to respective TfD groups. Please refer to Annex 2: Asset Disposal Tables.

2.2.2 Case Studies and Media Reports

A brief selection of communications is included in Annexes 3/4; other communications were shared throughout the course of the project.

2.2.3 Final Data Collection

As agreed with Cowater International in 2015, July-December 2016 performance data of HRH trained CSBAs from the selected communities could not be provided as the data collection mechanism at the field level was completed as of June 2016, so data from CSBAs were compiled at Upazila and district level, sent to DGHS and DGFP MIS and uploaded in the District Health Information Software (DHIS 2). Please refer to Annex 5: CSBA Performance for a summary of this data.

2.2.4 Finance Overview

The total budget for this project (Outcome 500) was CAD 4,243,948. The budget per the original contract was CAD 3,896,782, then in December 2014, in amendment #1 to the contract, Cowater International allocated an additional CAD 66,000 to the budget to improve the quality of care through skill enhancement training and practice; increase coordination with the GOB through round table meetings with MOHFW and other relevant stakeholders; and to strengthen the verification of monitoring data from HRH trained CSBAs. In June 2015, by way of contract amendment #2, Cowater

International allocated an additional CAD 281,166 to the budget to support the training of additional CSBAs, as well as to support direct staff costs for 5 project staff and direct office costs.

As the majority of the project activities were completed by the end of June 2016, and because Plan International Bangladesh experienced a significant budget shortfall due to the weakened Canadian dollar, the full time HRH project staff contracts ended as of the end of July 2016. For the data collection (i.e. # of PNC and # deliveries by CSBAs) during September 2016 and December 2016, Plan International identified a more cost effective approach to ensure the availability of this data during these final months. Rather than hosting quarterly meetings with statisticians of Upazila and with private sector CSBAs, the data was collected from the Ministry of Health reporting system (DHIS2) by a Plan International Bangladesh Health Specialist (who charged their time to the HRH project). It was felt that leveraging the government's own system for final data collection would help to encourage sustainability of that system after the end of the project. This approach provided Upazila/District data as the total number of deliveries and number of PNC visits conducted by CSBAs from the Upazila or District, which served as a proxy for the HRH-specific CSBA data. The data that was collected has been included in this report.

The actual spend against the budget, and final variance analysis by budget line, can be found in Annex 7.

2.3 Challenges and Lesson Learned

2.3.1 Political and Security Considerations

Political unrest and instability can disrupt project work and travel around the country. This was considered as a medium risk at the outset of the project. However, during the project implementation period, it became a major risk factor. Political unrest, together with strikes, continued in all parts of Bangladesh in 2013 and in the first quarter of 2014, and was unpredictable. There were 93 days lost either due to Hartal/strikes/blockades in 13 months, from January 2013 to January 2014 (please refer to Annex 1 for details). The project locations were in rural or peri-urban areas (Hatibandha, Kaligonj and Patgram Upazila of Lalmonirhat district) which were seriously affected by local political unrest or strikes. Project design and implementation was based on involvement of local community groups to build community participation. Almost all community group members live within the community they serve, or come from the adjacent communities/villages. However, in the event of unrest at the national level, the project team tried to address any issues through ongoing consultation and involvement of the community groups and other counterparts.

CSBA training was ongoing in different districts during this time of political crisis and the training venues were located at district level. Training activities were not hampered severely, except the movement of some CSBA trainees. Monitoring activities from central level as well as local level was hampered severely as movement was restricted during Hartal/Strike/Blocked period. Continuous communication was established with partner organizations in these training sites. Additionally, training coordinators established effective communication to avoid any undesirable situations.

2.3.2 Government engagement/resource limitations

Involvement of the government was crucial for this project. National level government conducted monitoring visits but the level of involvement fluctuated due to the frequent changes in policy level positions. Rapport building at district level was slow, due to the frequent transfer of such positions.

There was limited coordination between Civil Surgeons and Deputy Director of Family Planning in regards to selection of the candidates from the health facilities employees (FWA, HA, CHCP) for

CSBA training. As a result, some of the training centers started training with a lower number of CSBAs per batch (e.g. 14/15 CSBAs 18 CSBAs per batch), which raised the cost per CSBA training.

During selection of private CSBAs, the project ensured that representatives of local government as well as local health authorities were aware on the selection criteria as their reference point when selecting and/or recommending a potential CSBA candidate.

The GOB was reluctant to provide adequate human resources (e.g. an OB/GYN consultant as well an anesthesiologist were not available for most of the project implementation period) to make the EmOC service effective. Additionally, the lack of coordination between the two line directorates at the Union, Upazila and district levels (HS and FP) hampered the project activities.

Although FWVs were the first line supervisor (clinical supervision) to ensure CSBA activity at field level, they were not available in all unions. Similarly, only one MO-MCH was available in Aditmari Upazila and it was vacant for the other four Upazilas. Additionally, EmOC service was hampered as OB/GYN consultants and anaesthesiologists were not available most of the project period.

There were varying views on the CSBA program versus midwifery training among the Ministry of Health directorates at local level which was compounded by limited resources at the District and lower levels. CGs and CSGs were observed to more focus on managing health facilities rather than supporting in referrals and promotion of CSBAs, and supervisors of CSBAs seemed to be more focused more on reporting than on undertaking appropriate supervision of CSBAs performance. The line supervisors of the government line directorates, especially HIs/AHIs and FPIs were engaged on some of the supervisory activities in the field but not as much on others; for example, FWVs were engaged with supervision and reporting of both the general work and clinical performances of CSBAs, but they seemed to be more interested in collecting data rather than playing their role as a mentor/supervisor.

The project also identified several CSBAs who were not conducting frequent NVDs and became less confident in doing so, so they received Skills Enhancement Training. These CSBAs' confidence could be further increased by connecting them with appropriate health facilities for practice. However, a lack of 24/7 EmONC facilities and services at District and Upazila level facilities limited the opportunities for CSBAs to enhance their skills.

The government CSBAs under different line directorates (FWA under Family Planning and Fe-HA under Health Services) were intended to work together with NGO and private CSBAs however the project observed that there was limited coordination between the two line directorates at the Union, Upazila and district levels (HS and FP) which meant there was also no formal coordination between CSBAs from these two directorates. Additionally, the district level MCWC was used as one of the key referral centres, where most advanced facilities were available for maternal and newborn complications. Due to a lack of adequate coordination between HS and FP line directorates from the district level downwards, facilities and staff resources under the FP line directorate could not be optimally utilized for referral services.

There was also no provision in the original project design to improve the quality, availability and accessibility of services in the referral centres, especially in the government facilities at the Upazila and district levels and minimal opportunities for the government to invest in referral centres to provide referral services. This has resulted in a growing frustration among the patients referred to the government facilities. Additionally, inadequate and unavailable referral services in the centres discouraged patients and CSBAs from seeking care and promoting referrals respectively.

There was no provision to provide incentives (cash or in-kind) for private CSBAs, who were doing similar work to those were trained by Government and some NGO-trained CSBAs were paid staff, such as BRAC-trained CSBAs. When initially recruited, private CSBAs were told that there would be

no financial incentive provision during the project implementation and they accepted it; but these CSBAs maintained hope that eventually they would be compensated, either during the project or directly supported by communities. However, there was no financial support designated for private CSBAs in the project, and community members expected CSBAs to be compensated by the patients they served. In practice, this was extremely inadequate, and therefore some private CSBAs gradually became inactive. It was acknowledged that the lack of formal functional linkage and support from the DGHS/ DGFP limited their engagement at the field level.

Government CSBAs as well as their line supervisors were not provided any incentives (cash or in-kind) and, as a result, many of them were reluctant to perform what were considered to be additional duties.

CSBAs, with the help of CGs, were mainly responsible for referring patients to the higher level health facilities. The aim was to make sure that patients referred to the centres were getting quality, timely and adequate referral services. In many cases, CSBAs had to accompany the patients to ease their concerns of being mistreated by the referral centre's staff, as well as to get feedback on the services they received. However, an appropriate feedback mechanism for referral services was not available.

Reporting from CSBAs improved dramatically in Lalmonirhat district and it reached almost 100% in this district. As a result of this success, both DGHS and DGFP appreciated it and requested HRH project to orient this model to Health and Family Planning Officials of the other 16 Districts (132 Upazila) where the project provided this training. The average reporting of CSBA performance increased to 91% in Year 5 in 17 HRH project districts, which was appreciated by the government officials.

Overall, the CSBAs and the activities of CSBAs seemed to be a priority area for government as Office of Prime Minister put emphasis on CSBA reporting and performance. Despite all the challenges and difficulties faced by the HRH project, the progress that the project contributed towards government's commitments to ensure skilled assistance during delivery was in Lalmonirhat district was well recognized by the government of Bangladesh. As a result Lalmonirhat was considered as "Model of CSBA Program" in Bangladesh.

2.3.3 Logistical Difficulties

Adequate training venues for conducting CSBA training were not available at the inception stage of CSBA training. As a result, CSBAs from Panchagarh district were taken to Kushtia training center. However, due to long distances between CSBAs' place of residence and training venue, the initiative was not successful and CSBAs in this center discontinued their training. Similarly, CSBAs from Khagrachari and Kishoreganj were taken to Feni Nursing institute and CSBAs from Rangamati were taken to Cox's Bazar Nursing Institute as there were no CSBA training centers in Khagrachari, Kishoreganj and Rangamati. This arrangement created dissatisfaction among the CSBAs.

During the initial stage of the project, some of the CSBA training venues were not equipped properly so the project provided materials such as Over Head Projector (OHP), quality transparent sheets for OHP sessions, and flip charts with easel stands. In some training centers the accommodation facilities for CSBA trainees were not available in government facilities so, accommodation for CSBA trainees was arranged outside of the training venues by renting private premises.

Graduate CSBAs were not equipped with necessary registers and reporting formats to record their performances. At the initial stage, graduate CSBAs recorded their activities in their usual exercise books and followed no structured formats. As there was no structured register and reporting format for CSBAs, it was hard for CSBAs to record their activities as CSBAs. At the same time it was also difficult to collect data on their performance. During the CSBA coordination committee meeting, the

government officials requested Plan International Bangladesh to provide a CSBA Register and reporting format to all CSBAs in Bangladesh. In response, Plan International Bangladesh provided CSBA registers and Reporting formats for all CSBAs of the 17 HRH project districts (3,800 Registers and 3,800 Reporting Formats). The initiative was highly appreciated by the government as they have included this issue in the OP (Operational Plan) of an upcoming sectorial program.
Health Inspectors (HI), Assistant Health Inspectors (AHI) and Family Planning Inspectors (FPI) were the immediate supervisors of CSBAs (FeCHCP, FeHAs and FWA). No transportation facility and/or incentives were available for these immediate supervisors to monitor CSBA activities. As a result, quality CSBA activity was not ensured in most of the cases due lack of field level monitoring.

Each district had a pool of 15 trainers to conduct CSBA training. However, due to frequent transfer, many of these training centers suffered from lack of quality trainers. Though the HRH project provided ToT of CSBA training to 134 trainers, both from government as well private side (trainers from LAMB Hospital and Kumudini Hospital) the required number of ToT trained trainers could not be ensured in all training centers. This had an impact on quality CSBA training as facilitators without ToT had to be selected to continue the training.

The Supervision and Reporting model proposed that graduate CSBAs who were weak or had less confidence in conducting NVDs in the community would be supported to enhance CSBA's clinical skills through UH & FWC and UHC. However, none of the FWCs and UHCs in Lalmonirhat district was prepared to support CSBAs for this specific purpose due to the lack of logistical support (i.e. lack of Human Resources as well as availability of adequate clinical facilities).

The project developed a Gender Responsive Referral service to link CSBAs with Primary, Secondary and Tertiary health facilities to address emergency cases in Lalmonirhat district. However, the referral centers were not prepared to address the referral cases due to lack of human resources as well as availability of adequate clinical facilities. Additionally, none of the UHCs had the 24 hours EmOC services due to lack of adequate human resources, such as OB/GYN consultant and anesthesiologist.

2.4 Recommendations

Based on the challenges and lessons learned, the following recommendations are presented for consideration in the design and implementation of future CSBA programming:

- Build a sense of ownership among the officials and staff of the government line directorates from the District to Union levels through increased and consistent involvement of the District level team, and by establishing a separate 'Coordination Unit' comprised of members from GOs (DGHS-DGFP) and NGOs. Additionally, advocacy with top-level management would help to ensure that the District and community level officials and staff are taking the lead in implementing, coordinating and managing project activities.
- Fill the key positions from Union to District level to ensure clinical support to CSBAs as per need.
- Keep a balanced focus between supervision and reporting to foster the entire supervision and performance reporting mechanism and to strengthen management and routine clinical skill building of CSBAs.
- Ensure key staff and 24/7 EmONC facilities are available at District and Upazila hospitals and at MCWC. Additionally, improve and rehabilitate (minor renovation and equipping) the existing labor units (EmOC and EmONC), services and facilities at District and Upazila level hospitals and the MCWC. This is the key to ensuring continuous improvement of CSBAs' skills and confidence in clinical performance, as well as improving accessibility of the referred patients.
- Establish a feedback mechanism for referral centers to identify strengths and weaknesses in the referral system.
- Incorporate the use of Inter-Personal communication (IPC) based awareness as an intervention in the future programs.

- Assign Upazila and District level focal persons to lead CSBA program for supervision, monitoring and reporting.
- Continue CSBA performance review through supervision and monitoring and capacity development.
- Ensure provision of incentives, rewards and replenishment of basic supplies to CSBAs (both public and private) without any interruptions.
- Adapt TfD scripts, such as messages and characters according to the intended audiences, e.g. the health issues of both younger and multipara mothers.
- Continue to support initiatives to promote referral linkages and mobilize local resources (i.e. raise funds) to improve facilities and services and sustain them through CGs, CSGs and UPs.

2.5 Conclusion

Outcome 500 of the HRH project contributed to improving maternal and neonatal health conditions by improving health care seeking behaviour by women, particularly from families in poor and excluded communities, through promotion and utilization of CSBA services. The evidence of the success in Lalmonirhat district, the pilot district of the CSBA program, is that CSBAs contributed over 57% deliveries in the district whereas the national average in this area is below one percent.

The key learning from the project reinforced that placing appropriate monitoring and supervision for CSBAs and involving frontline workers and supervisors is critical to support CSBAs in their provision of quality MNCH services.

Further, district-level ownership needs to be backed up by support at national level for sustainability and scale-up. The Register and Reporting Format developed by the project can serve as useful resources for Government of Bangladesh for improving the MNCH status in Bangladesh. However, CSBAs cannot act alone, and are part of a larger health system, and therefore require the support of the overall system, which involves collaborating with several stakeholders to ensure the access to emergency obstetric care in the case of life-threatening complications that cannot be managed by CSBAs.

Annexes

Annex 1: Strikes-Hartal Summary

Annex 2 : Asset Tables

Annex 3 : Case Studies

Annex 4: Media Reports

Annex 5: CSBA Performance

Annex 6: BCC Materials

Annex 7: Financial Report