Safe Motherhood Promotion Project

Operational Guidelines on Community Support System

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On
Community Support System

Safe Motherhood Promotion Project

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Abbreviations

AHI	Assistant Health Inspector
CARE	CARE Bangladesh
CBO	Community Based Organizations
CD	Community Diagnosis
CS	Civil Surgeon
DC	Deputy Commissioner
DDFP	Deputy Director Family Planning
FGDs	Focused Group Discussions
FPI	Family Planning Inspector
FT	Field Trainer
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GOB	Government of Bangladesh
H&FP	Health and Family Planning
HA	Health Assistant
HFWC	Health and Family Welfare Centre
HI	Health Inspector
IDI	In-depth Interview
JICA	Japan International Cooperative Agency
KII	Key Informant's Interview
LGI	Local Government Institutions
LLP	Local Level Planning
MNH	Maternal and Neo-natal Health
MOHFW	Ministry of Health and Family Welfare
MOMCH	Medical Officer Maternal and Child Health
NGOs	Non Governmental Organizations
NNP	National Nutrition Project
PLA	Participatory Learning for Action
PPP	Participatory Planning Process
PRA	Participatory Rural Appraisal
SA	Situation Analysis
SACMO	Sub Assistant Community Medical Officer
SMPP	Safe Motherhood Promotion Project
UFPO	Upazila Family Planning Officer
UHFPO	Upazila Health and Family Planning Officer
UNO	Upazila Nirbahi Officer
UP	Union Parishad
UPC	Union Parishad Chairman
UPHFPSC	Union Parishad Health & Family Planning Standing Committee
UPIC	Upazila Implementation Committee

1.0 Introduction:

CARE's Safe Motherhood pilot program revealed that establishing community support system (CmSS) is effective for timely referral of women with obstetric complications through devising innovative community funds, transportation, blood donations etc. Safe Motherhood Promotion Project (SMPP) has been using the experience of CARE Bangladesh for establishing CmSS in Narsindi district since December 2006. The effectiveness of CmSS for increased use of EmOC services has been documented (DSI and NIRAHPAD MA project evaluation reports) and acknowledged by the MoHFW and other stakeholders. Thus, there are demands for wider replication of this approach.

This document outlines the operational guideline of establishing CmSS based on the experiences of SMPP project.

Why are Community Support Systems Important?

There has been a growing realization of the myriad problems facing Bangladesh, especially in relation to health and environment. These problems are so large and complex that governmental and NGO efforts will not be adequate without effective participation from the community. Community participation has been one of the Primary Health Care pillars since the Alma Ata Conference in 1978. Community participation in Bangladesh has included housing satellite clinics and forming village health committees. However, a closer look reveals that community participation efforts have been sporadic. A systematic attempt to achieve effective community participation in health matters has largely been ignored.

While most pregnancies occur without any problems, about 15% develop complications requiring medical interventions. These complications may arise suddenly, requiring prompt action without time to prepare. Many times collective and proactive *community action* is required for these women to receive EmOC services in a timely manner.

Table provides some important causes that affect decisions to seek care when needed.

- Most births and deaths occur at home. *If complications arise at home, travel of some distance may be required which may causes delays in accessing services.*
- Families lack of access to cash. *Only about a third (33-40%) of husbands reported having some savings for possible obstetric emergencies.*
- Community norms are not conducive to women accessing EmOC services in a timely manner.

Source: DSI Baseline

The following barriers that women face in accessing life saving maternal health services:

A. Distance to the comprehensive EOC facilities

Distance to the comprehensive EOC facilities ranging from 1 km to100 km, depending on the location of the public hospital, private and NGO clinics. It greatly varies from urban to rural settings. In the urban settings, the average distance of the District Hospital, MCWC or NGO Clinic about 50Kms.

B. Time to Reach the EOC facilities

It takes more time to reach the EOC facilities in the rainy season due to the poor road conditions.

C. Mode of transport

The most common mode of transport available to reach the EmOC facility, as reported by the husbands across the areas, was a `rickshaw van', boat, microbus, ambulance etc.

D. Cost of Reaching a Facility

Community leaders reported that transportation costs to reach the EOC facilities varies by area and seasons. An ambulance or Microbus would cost about Tk.2000 (US$ 30).

E. Cost of the Accessing EmOC Services

Even though women are supposed to receive services free of cost, many times the family often has to buy medical supplies and drugs markets because they are not always available in the public sector facilities. The cost of feeding the woman and the family members while she in the facility.

The costs for C-Sections and blood transfusions vary depending on the sources of services. The following table presents the average cost by type of facility.

Cost of Key Services by Facility

	Private	NGO	Public
C-Section	12,000 Tk ($267)	5,000-6,000 Tk ($122)	3,000-4,500Tk ($89)
Blood Transfusion	1,000 Tk per unit ($22)	500 Tk per unit ($11)	300 Tk per bag ($7)

If the woman dies there is still the additional cost of her burial. This varies, according to social status; however, for a traditional Muslim ritual, the average cost to bury a rural poor woman is about Tk. 2,000 ($45).

Experiences of other organizations on community participation in health promotion:

Community Managed Health Program, Plan International

The Program: Community managed health programs by Plan International in Bangladesh are being implemented as integrated component with other four programs - (a) community health care, (b) education, (c) enabling environment, (d) micro finance (FES), and (e) disaster management. *The Strategy*: Involving child centered community development approach has been taken as key strategy in all the programs. The seven programmatic steps are followed: (1) rapport building in the community, (2) situational analysis using extensive PRA techniques, (3) problem analysis through problem tree, (4) participatory planning process, (5) implementation, (6) participatory monitoring, and (7) Evaluation. *The Project Areas & Modality*: The program has been implemented both in urban and upazila areas. On maternal death issue, Plan International has been working in addressing delay 1 and 3 for maternal deaths having partnership with local CBOs and NGOs. *The Lessons Learned*: (1) Working with communities and children proved that the poor are not helpless; if opportunities are given, they can take leadership to address their health needs very well. (2) Community participation has been greatly increased by utilizing the quality services and efficient use of resources. (3) Use of appropriate Participatory Rural Appraisal (PRA) tools and techniques proved as the key to mobilize communities to take action steps. (4) Community contribution could be increased by enhancing community capacity. It is possible to ensure the quality health services with formal partnership with stakeholders, particularly GOB. (5) Strengthening the CBO is a must in achieving the program goal with quality service.

The strategy, working modality and lessons learned are attached in the Attachment-1

Community Managed Health Program, UNICEF

The Program: The ComSS initiative has been undertaken to address the huge unmet needs of EmOC utilization in Bangladesh by tackling the first two delays, i.e., the delays in deciding to seek care and reaching the health facility. *The* Strategy: UNICEF has been working with partnership approach. GOs and NGOs are their partner. *The Project Area and Modality*: Two criteria have been used for selecting the six upazilas for piloting the Initiative. Firstly, those upazilas were to be selected that had comprehensive EmOC services available at the upazila health complex. Secondly, utilization of those services was poor in spite of their full-fledged availability. *The Lessons Learned*: (1) Health facilities continue to lack manpower, not because of poor human resource allocation but because of lack of motivation and commitment of the medical staff. (2) Often if the condition of the pregnant women worsens at the facility while waiting, she is referred to the district hospital causing considerable delay in receiving appropriate care. (3) The people are also disappointed with the quality of services at the facility. In general, the service providers are still not patient friendly. (4) The FWVs at the FWC are not present regularly. When pregnant women travel long distances to come to the FWCs for ANC/PNC services and have to go back without receiving those services, there is a lot of frustration and loss of faith on the health workers and the community support group. (5) Lack of coordination between health and FP is an another big

challenge. Coordination between health and family planning is poor as well as between the national, divisional and district level administration. (6) With regard to forming CSGs, it is extremely difficult when there is a political or community feud in a selected village. (7) Unless the CSG members are empowered with tools like the referral slip or ID card, the service providers cannot be made accountable.

The working modality and lessons learned are attached in the Attachment -2.

Community Managed Health Program, ICDDR,B

The Program: This initiative has been taken by ICDDr,B and implemented it in the costal belt of Cox's Bazar district. *The Project Area and Modality:* Achieving community participation in health matters remains a major challenge. ICDDR,B implemented community managed initiatives in the Chakoria of Cox's Bazar. It was implemented in 1994 through indigenous, village based self-help organizations in Chakaria. The project started with a team of six community organizers (3 female and 3 male), two self-help trainers, two social researchers, and a field team leader. The project started with non-medical personnel. This was done intentionally, so that the field staff could in no way start offering curative health services to the community. After a year, 2 paramedics and a public health physician joined in the team. Six community health workers with HSC, recruited from the locality. After reviewing the status of initiatives in the villages, all members of the staff reached the conclusion that initiatives taken by the villagers are the only ones sustainable in the long run. Thus, if health can some how be brought onto the agenda of these existing initiatives, it will not only cause them to initiate health activities, it will also foster adoption of health – and hygiene related behavior in turn leading to improve health status of client populations.

The lessons learned are attached in the Attachment -3

Operational definition of proposed CmSS

CmSS is a mechanism for establishing a system at the community level, through collective efforts of the people, which aim to provide support to pregnant women during any obstetric emergency.

The purposes of creating a CmSS are to:

- Facilitate timely referral of women with obstetric complications to an appropriate EOC facility;
- Foster an enabling environment in the community, and ultimately at the household level to support women in accessing EOC services in a timely manner, and;
- Create awareness among community about danger signs of obstetric complications and available services at different facilities.

In order to foster a supportive environment for women to access skilled birth attendants and EOC services, activities need to occur at two levels. Some efforts need to be conducted at the larger community level to create a favorable environment. Activities might include orientation of local and religious leaders, community leader's discussion with service providers.

Other activities need to focus directly on establishing a CmSS, if the community desires. Activities include community diagnosis, community mobilization meeting, formation of executive committee, development of operational guidelines, and monitoring visits to support CmSS.

2.0 Principles that should keep in mind to establish A Community Support System

- The CmSS must be initiated by the community.
- The facilitator of the village meeting must be a community member/facilitator.
- The community must agree on how to establish and implement the system.
- The community must implement and monitor the system.
- The community makes the decisions about the system.

3.0 Steps to Implement a Community Support System

The following 12 steps could be undertaken to establish the CmSS, which are outlined below:

Step 1: Select the area of villages
Step 2: Identify Community Facilitators
Step 3: Prepare Community Facilitators for conducting community diagnosis
Step 4: Conduct community diagnosis
Step 5: Share findings with the selected community members to sensitize them
Step 6: Held village meeting to be led by community facilitators
Step 7: Formation of a CmSS
Step 8: Implement the Community Support System
Step 9: Disseminate Information about the CmSS
Step 10: Provide Follow-up and Monitoring
Step 11: Capacity building and sustainability of CmSS
Step 12: Develop union and upazila federation of CmSS

Now the detailed steps are:

Step 1:Select the area or villages

The facilitators (may be GoB or NGO staff) will identify the specific community or village for developing CmSS. The villages/communities could be identified considering some indicators such as geographic location, distance from EOC facilities, the incidence of maternal deaths and complications, and community interest etc. During the UP planning workshop, the probable areas for establishing CmSS would be selected. The respective UP member and HA/FWA will take responsibility to mobilize the communities involving local appropriate community facilitators.

Step 2. Identify Community Facilitators:
Through informal discussions with key informants, a few proactive volunteers will be identified to conduct the community diagnosis exercise and facilitate the village meeting. The proactive volunteers may be school teachers, elected Union Parishad Members, youth club members, village doctors, GO/NGO workers and elite.

The commitments of some community volunteers for facilitating the CmSS process could be mobilized and expressed publicly during the UP planning workshop.

Step 3. Prepare Community Facilitators for conducting community diagnosis:
The resource person (may be NGO staff like CARE) for CmSS may organize a half -day meeting with the volunteers (community facilitators) to prepare them for conducting the community diagnosis. This session will ensure that the community facilitators will be given information on the followings:

- status of maternal deaths and morbidity in Bangladesh;
- medical and social causes of maternal deaths and morbidities using the case study findings;
- the 3 delays in accessing and receiving EmOC services;
- current government and NGO maternal health program; and
- Ways that the community can play an active role particularly in addressing the barriers to receive EmOC services from the facilities.
- ways to conduct community diagnosis and resource mapping of the target catchments areas

In summary, the orientation will provide information on the basic maternal health information, importance of community participation, roles of community facilitators and techniques of community diagnosis.

Step 4:Conduct community diagnosis

The steps for community diagnosis are outlined below:

a. Conduct resource mapping**:** The facilitators will conduct a resource mapping exercise. They will identify the various community agents, local resources, and experiences with maternal

deaths and/illnesses. Resource mapping will help the facilitators to understand what resources are available and how they could build upon them. For example, identify local NGOs, clubs, committees (school, bazaar….) or any credit groups who would be interested to establish and implement community support for the women with obstetric complications using EOC services.

b. Conduct case studies of maternal/newborn death: Once the community/villages are selected, the facilitator will identify the families having maternal and newborn death history and collect detailed information about the cases of death. The facilitator will use other participatory techniques with the community to collect additional data to understand the local situation (i.e., focus group discussions to learn about issues, resources, events, and manpower this needs to be more specific) that could be used to facilitate in the establishment the CmSS.

If the community or the staff found any case of maternal death or morbidity, they will contact the family and conduct an in-depth interview to understand what happened that may have contributed to the death.

The information will cover pregnancy care, delivery process, roles and practices of delivery attendants, causes of not using health services that include social, economical, cultural causes etc.

c. Individual discussion with the key gate keepers: The school teachers, TBAs, local elite, local political leaders and religious leaders would be important key stakeholders in the community. Individual and group discussions will be held to make them understand on the importance to address the maternal health issues and to identify their potential roles in the development of CmSS.

Process of Community Diagnosis are attached in the Attachment -4

Step 5. Share findings with the selected community members to sensitize them:
The summary results of the community diagnosis will be shared with the selected community members (senor opinion leaders) and key stakeholders at the appropriate opportunities (i.e., individual discussion, tea stall meeting, small group meeting etc.). The purpose of such individual meetings is to make the key opinion leaders of the village understand the issues and mobilize their commitments as it will help to take appropriate decisions during the village meeting.

Step 6. Held village meeting to be led by community facilitators
The community leaders, along with the community facilitators, arranged for a village meeting to have this discussion as an agenda item. Usually, there may be between 50-60 people, both men and women, who regularly attend these meetings. The facilitators will try to encourage the community leaders to have a representative from each para (small part of village) and each age group.

During these discussions, the facilitators will share the following information:

- maternal death or morbidity status in Bangladesh;
- medical and social causes of maternal death and morbidity;

- case studies of the particular area to help the community visualize the problems; and
- Three *3 delays* (social and physical barriers) in receiving EmOC services.

After sharing this information, the community usually discusses how to make the situation better. After informal discussions, the facilitator would ask one of the community leaders to arrange a village meeting to discuss these issues further with the whole community.
The purpose of sharing this information with the community is the hope that participants will understand the issues surrounding maternal deaths and that they will make a commitment to do something to prevent maternal deaths in their village.

Two major mindset changes need to occur before a CmSS can be seriously discussed:

- The community needs to understand the importance of not letting women die from lack of intervention.

- The community needs to understand that they can intervene to make a difference in the situation.

Once this occurs, then discussions about an actual community support system can be undertaken. On average, it takes 2-3 meetings to develop a consensus among the community to agree to form a CmSS.

Step 7: Formation of a CmSS
a. Decide what type of support system they want to implement:
First, the community must realize the importance of establishing a CmSS to support women with obstetric complications, Then the community can discuss and decide which type of system (s) or support (s) is most needed and feasible in their situation.

b. Form an executive committee: In order to sustain the community support system, the community may form an executive committee consisting of 7 to 15 members. All households of the identified catchments area were the members of the general committee. The executive committee will be selected through a verbal vote during the general village meeting. In addition, once the executive committee is formed, there is another verbal vote to elect a chairperson, vice-chairperson, secretary, and cashier. If they form system to generate a fund, they also select a member (usually a youth) to collect money.

If the CmSS will run by an existing clubs or formal committees, then no needs of forming executive committee.

c. Develop operational guidelines: With the help the Service Promoter/Community Mobilizer, the executive committee members will develop operational guidelines to operate the CmSS. The main contents of the guidelines included:

- eligibility for membership;
- roles and responsibilities of executive committee members;
- procedures for electing executive committee members;
- amount and frequency of deposited money or other resources;

- procedures for community use of the fund, including reimbursement policy;
- procedures for the manpower system as support for women with obstetric complications; and
- ways to resolve conflict as it arises within the executive committee or the community.

The CmSS representatives would revise the guidelines as and when necessary.

A CmSS constitution is attached at Annexure – 5.

Step 8. Implement the Community Support System

According to the operational guidelines, the community will implement the CmSS. Usually there will be monthly meetings to review the progress of the CmSS and often times the FWAs, TBAs, elected officials, school teachers and imams would be invited to the meeting. As the communities gained confidence, they will begin exploring other ways that the CmSS can be beneficial to the community. However, the frequency of meeting may vary from community to community as per local people's conveniences.

Step 9. Disseminate Information about the CmSS

Information of the CmSS will be disseminated through four main channels:

1. village leaders through their regular contact with the community members;
2. imams who meet with men weekly at mosque;
3. GoB workers such as FWAs, FWVs as they conducted normal job duties, and;
4. community workers such as TBAs when they come in contact with pregnant women and their families.

It was found that the local TBA plays vital role to identify the pregnant women, contact with family members and report back to CmSS management committee.

The facilitators will also encourage the communities to maximize opportunities to disseminate information about the CmSS. For example, while observing national Safe Motherhood day, members of the CmSS may be presented with awards for their efforts.

Step 10. Provide Follow-up and Monitoring

The CmSS committee will carry out self monitoring. During monthly meeting the CmSS management monitor/review the followings:

- Update the pregnancy (including new pregnant women), use of ANC services, normal delivery, complications and referral list using pictorial methods
- Status of resources collection (funds and other resources)
- Status of expenditure status and purpose
- Other activities/initiatives etc.

The external resource person will jointly visit the CmSS to ensure that they are operating according to guidelines. During follow up visits, they will also address weaknesses of the CmSS and assess the number of women with obstetric complication who had used the CmSS. In the beginning, the facilitators may need to attend most of the community meetings, but as the executive committee matured their participation will be diminished.

CmSS monthly meeting process is attached as Annexure-6

Step 11. Capacity building and sustainability of CmSS
The capacity of CmSS in terms of planning, participation (gender, socio-economic status, ethnicity, area representation), leadership, governance, accountability and transparency, linkage, sustainability, and technical skills could be assessed by using qualitative tools. The CmSS may need training on specific areas such as Organization development included planning, participation, leadership, governance, gender and financial management. Both in-service and on-the-job training would be used to address these issues.

A special effort need to be taken to linkup the CmSS with as many as GoB and NGO resource institutions (local government bodies, health facilities, social welfare department) as well as to recognize the CmSS efforts and to create an opportunity to mobilize support.

A sustainability framework for CmSS is attached as Annexure-7

Step 12. Develop union and upazila federation of CmSS

In order to institutionalize the CmSS, federations will be established both at union and upazila level with the participation all CmSS. It may be known as union CmSS federation and Upazila CmSS federation. The purpose of developing the federation is to develop apex body, raised common voices, and organize yearly gathering with the participation of CmSS members. The yearly gathering preferably on Safe Motherhood day will be participated by all relevant stake holders such as UP chairmen, UNO, Health and FP managers, other GO departments, NGO, civil society organization like press, media etc. This yearly gathering will give them the opportunities to disseminate their achievements, mobilize further commitments and supports from service providers and also their issues and concerns.

The Terms of Reference of CmSS Federation is attached to Annexure – 8 and 9.

Attachment 1

Community Managed Health Program
Plan International

Plan International has been working in Bangladesh since 1994 with five program components, which are (a) community health care, (b) education, (c) enabling environment, (d) micro finance (FES), and (e) disaster management. As a strategy, Plan used to follow child centered approach for its all programs. The typical steps in implementing the community managed health programs are: (1) rapport building in the community, (2) situational analysis using extensive PRA techniques, (3) problem analysis through problem tree, (4) participatory planning process, (5) implementation, (6) participatory monitoring, and (7) Evaluation. It's working station are mainly at Upazila level both in urban and rural community, namely Jaladhaka (Nilphamari), Hatibandha (Lalmonirhat), Chiribandar and Khanshama (Dinajpur), Sreepur (Gazipur), Malibagh and Shyamoli (Dhaka).

Situational analysis is the key step. Usually it captures the barriers and opportunities available in the community. Plan starts work from the village by creating a CBO at the beginning of their work in the village. The approach targets H&FWC in the union by forming a clinic management committee. Plan gave technical assistance to the clinic management committee at the H&FWC consisting of 10 to 12 members. A TOR to keep the committee functioning was developed where the roles and responsibilities, frequency of meeting, monitoring of the program are recorded. The referral hospital is Upazila health complex where EmOC service is available. In the community level, in every village there is a CBO and its memberships varies from 20 to 25 members where 50% members are male and 50% members are female.

In the maternal health issue, Plan has been addressing the delay 1 and delay 3 at the moment for the maternal and natal deaths issue. At the outset Plan completed the wealth ranking of all families in the village to provide rationalization of health services. Two types of training were given for the CMC members: (a) Program management training, and (b) Financial management training. Similar training were also given with a short duration to the CBO members in the village.

Plan emphasizes those problems that could be solved locally using local resources both human and financial. Demand side interventions and capacity building of local organizations were given preference.

Attachment 2

Community Managed Health Program
UNICEF

The Community Support System (ComSS) initiative has been undertaken in an attempt to address the huge unmet needs of EmOC utilization in Bangladesh by tackling the first two delays, i.e., the delays in deciding to seek care and reaching the health facility. It has been realized that demand for services now need to be generated through community-based interventions that educate and mobilize pregnant women and their families to increase their access and ability to obtain these services.

In late 2004 during a divisional review meeting on EmOC participated by government officials and UNICEF it was observed that the performance report of EmOC facilities reflected suboptimal utilization of some of the health facilities. They discussed the prevailing situation in the country of high maternal mortality and morbidity rate, low esteem and violation of women's rights in the society, and low utilization of health services. They reached the decision to work with the community to create demand for services and establish a linkage between the community and EmOC facilities.

Based on previous experience in the Birampur Upazila of Dinajpur District and other similar types of initiatives implemented in the country, it was decided that a community support system will be developed in some selected upazilas to increase the utilization of EmOC services. While previous efforts had attempted to improve the health facilities, quality of care activities and create community demand through social mobilization activities, it was now felt that those efforts needed to culminate into a more concrete community support system. And so, under the leadership of the Bureau of Health Education (BHE/DGHS), the Community Support System Initiative was born.

Two criteria have been used for selecting the six upazilas for piloting the Initiative. Firstly, those upazilas were to be selected that had comprehensive EmOC services available at the upazila health complex. Secondly, utilization of those services was poor in spite of their full-fledged availability.

The key strategy was to design and implement the Initiative in a joint effort by the Bureau of Health Education (BHE/DGHS), UNICEF, CARE, local NGOs, Community Based Organizations (CBOs) and communities. Efforts are made to identify appropriate local NGOs and CBOs to follow up and support the functions of the community support groups. CARE Bangladesh has brought on board for a year to facilitate mobilization of communities in the six upazilas. However, the working modality and process learning will be used to develop further partnership arrangements with both UNICEF and BHE, as and when necessary.

The government focal points for the ComSS Initiative are the UH&FPO of the selected upazilas. They are supported by the HI, AHI, HA, FWA of the respective upazilas.

The funds provided by UNICEF for the Initiative is disbursed by BHE. The community mobilization activities were contracted in by BHE to CARE through a MoU. Three Project Officers from CARE have been appointed full time for this Initiative. They are each responsible for two upazilas, which means they dedicate 15 days to each upazila.

There is a Technical Coordinator giving 25% of time and a Health Advisor giving 10% of time to the Initiative.

Following lessons have been learned:

- An interrelationship is necessary to be established between the community and doctors and other service providers. Unless the CSG members are empowered with tools like the referral slip or ID card, the service providers cannot be made accountable.
- Unless CSG members are made known to the facility staff they will not get the service or know whom to approach and the staff would not know that they belonged to the group.
- If there is coordination between health and family planning staff it will be an easy enough task to activate, sustain and strengthen the group. It is a proven lesson that wherever there has been good coordination between the two wings of the health sector, programmatic efforts have yielded good results.
- UP members may be made advisors as their support is needed for the Initiative, but not as members of the CSG. In the past, groups which did include a UP member as the chairperson or secretary broke up after a defeat in the UP election. The group had to formed all over again.
- If the formation process is not followed correctly while creating a group it will not sustain. No matter how long it takes, the process should be followed.
- The formation process enables cultural development of the group members; they become more empowered; the woman's voice is raised and heard.
- The community stops cooperating if it thinks an effort/intervention is being made to serve the interest of others, not the community. Also, e.g., if they realize that a government staff is making them do their part of the work, they refuse to cooperate after a point. Their objection is 'you are taking salary for this work but you are making us do it.' They feel betrayed.
- The health assistants are a big strength for this Initiative. In Shahjadpur, the female HA did the mapping whereas in other projects the community has to pay for such services. The HA in Bauphal is extremely committed to the CSG cause and does everything on his own initiative.

Attachment 3

Community Managed Health Program
ICDDR,B

Achieving community participation in health matters remains a major challenge. ICDDR,B has been implemented community managed initiatives in different places of Bangladesh. A focused one was implemented in 1994 through indigenous, village based self-help organizations in Chakaria, a remote area of Bangladesh.

The project was started with a team of six community organizers (three female and three male), two self-help trainers, two applied social researchers, and a field team leader. The project stated with non-medical personnel. This was done intentionally, so that the field staff could in no way start offering curative health services to the community. This would have undermined the promotion of preventive health activities and raised undesired expectations. After a year of operation, two paramedics and a public health physician joined in the team. Six community health workers with a minimum of 12 years of schooling, recruited from the locality, joined the project later.

All project staff went through an orientation program before starting work in the field. This orientation consisted of a participatory exercise to review the experience of the staff with respect to sustainable development in Bangladesh. It also included discussions about establishing relationships with the community, its social and power structures, locating casual meeting places in rural areas, the role of the indigenous Self Help Organizations in the society, and key people and resource persons.

After reviewing the status of initiatives in the villages, all members of the staff reached the conclusion that initiatives taken by the villagers are the only ones sustainable in the long run. Thus, if health can some how be brought onto the agenda of these existing initiatives, it will not only cause them to initiate health activities, it will also also foster adoption of health – and hygiene related behavior in turn leading to improve health status of client populations.

The project faced a number of problems: keep morale of project staff and the need for philosophical clarity, distrust among villagers and the need for a slow, transparent approach, countering the relief mentality by empowering respect for self-help, staying out of village feuds, underscoring the participation of women and the poor, and explaining what the demand for curative services entails.

The project put forwarded a number of challenges: keeping the wheel moving by showing benefits, maintaining the tradition of linking the public and private sectors, extending the process by demonstrating the example, The project concluded that the initiative could be successful elsewhere if not by invitation but by participation principle, not overtaking but following the community, using curative services as a platform for health promotion and finally restrained generosity. .

Annexure – 4

Process of Community Diagnosis

Preparation:

- Identify two to three persons from the community to facilitate the community diagnosis process
- Develop capacity of identified facilitators in the areas of case study writing, underlying causes analysis of death cases and resource mapping techniques
- Collect two or three maternal death cases as case writing guidelines

Community Diagnosis Steps:

- Analyzing underlying causes of death cases in terms of barriers at HH level, community level, religious faith and believes and delays doe to transportation problem,
- Identify possible solutions irrespective of all problems mentioned above
- Conduct resource mapping exercises in the community
- Document all learning (barriers and opportunities) in presentable forms like poster paper, black boards, etc.
- Conduct individual counseling with the community key personnel (UP chairman, member, female members, Imam, Teacher, Village Doctor, TBA, etc.)
- Preparation of the facilitator to present the findings with larger group at community level
- Organize a village meeting or series of meetings to complete the community diagnosis process
- Develop some actions to address the identified problems
- Formation of CmSS

Annexure – 5

CmSS Constitution – A Guideline

A CBO constitution consists of:

1. Name of the Samity (CmSS)
2. Objectives
3. Number of members [members of the local community will be the members]
4. Qualification of the members [interested to work for safe MNH services]
5. Selection of general members – eligibility criteria:
    a. S/He has to obey the constitutions and bye-laws of the samity
    b. S/He wants to work in groups for promoting the safe MNH services
    c. Give time and input for the welfare of the samity
    d. Honest, sincere and acceptable to the community
6. Selection of management committee – eligibility criteria:
    a. Honest and hard worker
    b. Inspired and efficient in group work for the MNH services
    c. Acceptable to community
    d. Literate and keeps financial records
    e. Ability to work and negotiate with GOB and NGO staff
7. Members of management committee (7 to 15 members)
    a. Chairman 1
    b. Vice-chairman 1
    c. Secretary 1
    d. Asstt. Secretary 1
    e. Treasurer 1
    f. Secretary – MNH 1
    g. Publication secretary 1
8. Working Committee – how many years and the selection procedure of the working committee should be written
9. The samity should have a work plan, like
    a. Identification of pregnant women in the area
    b. Ensure Antenatal check up for all pregnant mother
    c. Ensure birth planning for all pregnant mother
    d. Ensure regular follow-up for all pregnant mother
    e. Develop emergency fund for the mothers who need help
    f. Motivate mothers who identified as risk pregnancy to go to the hospital
    g. Keep liaison with EmOC service facilities and develop a network
    h. Address other problems like stopping adolescent marriage, VAW, stopping dowry system through playing active role in the community
10. Organize meetings
    a. Monthly Management Committee meeting
    b. One or two General meetings with general members
11. Equal rights for all members, like
    a. Distressed members
    b. Poor members

    c. Disable members
    d. Women, etc.

12. Distribution of responsibilities to members with task and deadlines
    a. Responsibility of Management Committee
        i. The chairman will call monthly meetings and check the information relating to pregnant mothers ANC, PNC, referral to hospital for risky mothers and child.
        ii. Supervise everyone about the progress of work, about the information of the meeting when and where the meeting will be held.
        iii. Financial management of CmSS – cash inflow and outflow, the balance, the mobilization of savings, etc.
        iv. The performance analysis (identification of pregnancy, taking services from service providers, etc.)
        v. Promotion of services in the local medias
    b. Responsibility of General Members
        i. To know the rules and regulations of the samity
        ii. To believe and maintain the rules and regulations of the samity
        iii. To publicize the activities of the samity in the working area
        iv. Inform the samity about any problem relating to pregnant mother and children and try to solve it individually or in group
13. Subscription of the members
    a. Fix up the subscription and inform the member immediately
    b. Collect the subscription regularly and develop a deposit for meeting emergency services
    c. Develop revenue generation strategy to keep the CmSS/CBO financial sustainable
14. Dissolution of membership from the samity
    a. Any activity against the constitution and bye laws of the samity
    b. Any activity against the interest of the Mother and children
    c. Any act caused to creating disturbances in the society
    d. Physically and mentally unfit

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Annexure – 6

Monthly Meeting Procedure of CmSS

Guiding Principles

- Typically meeting frequency is monthly but it depends upon the need of the CmSS
- The meeting conduction process is participatory
- Venue is within the community under informal sitting arrangement
- Use resource mapping and three registers (pregnant women register, meeting minutes register and accounts register) for monitoring the activity

Meeting Agenda

1. Resolution review of previous meeting
2. Performance review of CmSS activities
    a. No of new pregnant women
    b. Status of ANC and birth planning
    c. Status of complicated pregnancy
    d. No of deliveries
    e. No of patients referred
    f. No of supports provided
    g. No of Courtyard sessions
    h. No of male gathering
    i. Income and expenditure review
    j. Other achievements (early marriage, VAW, Dowry, etc.)

3. Next plan
4. Conclusion

Attachments 7

Indicators for Effective and Sustainable CmSS

Main Indicator	Sub Indicator
1. **Involvement of 2-3 appropriate Leadership with required capacity to lead the CmSS activities**	▪ Pro-activeness
	▪ Self Motivation with reasonable justification
	▪ Facilitation skills
	▪ Accepted by the community
2. All CmSS executive members are able to explain the 'WHY' Maternal and Neonatal health is important	▪ Know and explain the 5 danger signs with their consequences
	▪ Know and explain all 8 elements of Birth Planning
	▪ Know about available service center around their catchments areas and how to get services
	▪ Explain importance of collective community actions to reduce maternal and neonatal mortality and morbidity
3. CmSS has a constitution and are being followed or practiced by the CmSS member	▪ Has written constitution
	▪ CmSS member can explain the key components of the constitution
	▪ CmSS all executive member can explain their individual roles and responsibility
4. CmSS established formal & effective linkage with service center, UP, NGO and other GOB departments	▪ Participate in UP/FWC/UHC meeting
	▪ Recognized by GOB and others
	▪ Have written communication with GOB and NGO
5. CmSS executive member are able to monitor their performances regularly	▪ Collect and update Pregnant women list
	▪ Collect and update Newborn list

	▪ Update referral information
	▪ Number of women and community people are use CmSS support
	▪ Review and analysis their performances by using pictorial method/ Map
6. CmSS executive member are able to generate adequate fund and resources using different and innovative approaches	▪ Regular subscription from CmSS member
	▪ Individual donation
	▪ Institutional donation
	▪ Seasonal collection
7. CmSS practice a transparent accounting system	▪ Sharing income, expenditure and balance to all executive and general members, through- - Regular CmSS monthly meeting - Six monthly/ Annual general meeting
	▪ Address immediately if any issue raised by community regarding financial system and provide feedback to the community

Attachment 8

Terms of reference (TOR) Union federation of CmSS

Objective:

- To institutionalize the CmSS and its activities
- To raise common voice for ensuring quality service from different service center
- To mobilize different resources from different institution for further effectiveness of CmSS

Member of Union federation of CmSS:

Executive committee:

a) Executive committee develop by the representation of each CmSS. Every CmSS will select 1 or 2 member for this committee, but this number depends on number of CmSS in one union.
b) One president and one secretary will select from those selected member, rest of the member act as a executive member
c) Leadership will change in every year through vote or selection

Advisory committee:

Under the leadership of UP chairman, an advisory committee will form. Other UP members and union H&FP supervisor will the member of this advisory committee.

Roles and responsibility:

a) Federation will sit in every 3 month at UP office or FWC/RD
b) They will share each CmSS performances, challenges and future plan
c) They will engage in every H&FP national program/campaign
d) They will observe Safe motherhood day at union level
e) They will maintain close relation with Upazilla CmSS federation and different service center
f) They will mobilize resources for each CmSS from UP or any other sources

Attachment 9

Terms of reference (TOR) Upazilla federation of CmSS

Objective:

- To institutionalize the CmSS and its activities
- To raise common voice for ensuring quality service from different service center
- To mobilize different resources from different institution for further effectiveness of CmSS

Member of Upazilla federation of CmSS:

Executive committee:

d) Executive committee develops by the representation of each union CmSS federation. Every union CmSS federation will select 1 member for this committee.
e) One president and one secretary will select from those selected member, rest of the member act as a executive member
f) Leadership will change in every year through vote or selection

Advisory committee:

Under the leadership of UNO/ Upazilla chairman, an advisory committee will form. Other Upazilla Parishad members, upazilla H&FP manager, representation from press club and some social worker will be the member of this advisory committee.

Roles and responsibility:

g) Federation will sit in every 3 month at Upazilla Parishad or UHC
h) They will share each union CmSS federation performances, challenges and future plan
i) They will engage in every H&FP national program/campaign
j) They will observe Safe motherhood day at upazilla level
k) They will maintain close relation with Upazilla Parishad, Upazilla health and FP department and different department (Youth development, Social welfare, Women affairs etc.)
l) They will mobilize resources for each CmSS from Upazilla parishad or any other sources