

CASE 7

Integration of FP-MNCH Services to Accelerate Reduction of Maternal & Child Deaths: Bangladesh Experience¹

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BACKGROUND

“With the knowledge we now have, especially in the last few years, with the technologies we’ve created and with the rapid progress we’re seeing in places like Bangladesh, Ethiopia, and Rwanda, we know that we can do more to accelerate the global rate of reduction in child mortality dramatically.”

– Dr. Rajiv Shah, Administrator, United States Agency for International Development (USAID).
Briefing on *Global Child Survival Efforts: Every Child Deserves a Fifth Birthday*, Kaiser Family Foundation, April 23, 2012

Women and children are still dying in alarming numbers from preventable causes. Each year, 289,000 women (WHO, 2014) die from pregnancy-related causes and 6.6 million children die before their fifth birthdays – 44 percent of them in their first month of life. These statistics translate to 18,000 children under the age of five and 800 pregnant women or women in childbirth dying every day (UNICEF, 2013). The vast majority of maternal and child deaths are preventable. The disparity between rich and poor nations is still wide. A child born in a low-income country is approximately 18 times more likely to die before the age of five than a child born in a developed country. Over a lifetime, a woman’s risk of dying as a result of pregnancy and child-birth in a low-income country is over 40 times higher than in the United States. With a smart, focused, innovative approach, millions of mothers and their children can be saved, creating ripples of change that transform the future of families and their countries.

On June 25, 2014, the United States Agency for International Development (USAID) and the Governments of Ethiopia and India, in collaboration with United Nations International Children’s Emergency Fund (UNICEF) and the Bill & Melinda Gates Foundation, hosted a ministerial-level forum to celebrate the second anniversary of the *Child Survival Call to Action* and the launch of *Committing to Child Survival: A Promise Renewed*. Involving Ministers of Health from 24 countries, this high-level forum involved assessment of the challenges that remain in reducing preventable child and maternal deaths and identification of the steps needed to sustain momentum in the future.

Ending Preventable Child and Maternal Deaths (EPCMD) by 2035 is one of USAID’s top priority health initiatives. Currently, USAID invests 90 percent of its maternal and child resources in the

¹ The contents are the responsibility of authors and do not necessarily reflect the views of USAID or the United States Government. All information found herein is available in publicly accessible materials.

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24 countries that account for 70 percent of maternal and child deaths in the developing world. During this time period, USAID will extend coverage of proven, high-impact interventions to the most vulnerable populations in these high-burden countries. The EPCMD goals aim to reduce child mortality to 20 or fewer deaths per 1,000 live births by 2035, and maternal mortality to 70 deaths or fewer per 100,000 (USAID, 2014).

As part of these efforts on EPCMD, USAID Administrator Shah requested staff working with priority countries to test and analyze best practices, and to roll them out in all 24 priority countries during 2014. Recently, a rapid assessment was conducted in five of the 24 priority countries to examine the alignment of USAID's health programs with EPCMD goals, and within the context of evidence-based, costed national plans. The assessments examined the association between USAID planning, resource allocation, execution, the broader donor landscape, the involvement of all country actors, and the potential of "lives saved". Based on the assessment report, Bangladesh was selected as a high-performing country for the following reasons:

- Bangladesh has already achieved Millennium Development Goals (MDG) 4² and is on track to reach MDG 5³. The country has made remarkable progress in reducing maternal, neonatal, and child deaths over the last 20 years;
- Country commitment and Government of Bangladesh leadership have been essential in USAID's efforts to improve maternal, neonatal, and child health, particularly in bringing proven interventions to scale, such as integrated Family Planning-Maternal, Neonatal, Child Health (FP-MNCH) services; and
- Bangladesh has been leveraging government and donor resources to accelerate efforts to end preventable child and maternal deaths (USAID, 2014).

Yasmin Ara, the Project Management Specialist who led the FP-MNCH activities in Bangladesh, was requested to travel to the neighbouring country of Pakistan to assist in their MNCH efforts. She was assigned to lead the overall assessment of the health sector to help the country formulate their strategy for achieving the EPCMD goals. After she arrived in Lahore, she prepared for her first meeting with the Ministry of Health. She remembered the hard work that she and her colleagues both at USAID and the Ministry of Health of Bangladesh did to improve maternal and child health status in Bangladesh. She reflected on the dedication of her team, whose relentless commitment ensured the positive changes in the sector.

It was a great reward for Yasmin Ara and her team that through their efforts, Bangladesh had already achieved MDG 4 and was on the verge of achieving MDG 5. The EPCMD Beta Test team applauded their work. Now, it was time for Yasmin Ara to share her experiences with Pakistan and help them in planning strategies to reduce maternal and child deaths. It was expected that the Bangladesh experience could identify best practices for countries to adapt as they reached the same level of performance. USAID was now planning to replicate the lessons learned and best practices from Bangladesh in countries that were facing ongoing challenges in meeting the goal of accelerating mortality reductions. The major driving force identified as the key to Bangladesh's success was the scaling-up of integrated FP-MNCH services to increase access and expand reach for the target populations.

² Reduce Child Mortality

³ Improve Maternal Health

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BACKGROUND: BANGLADESH ACHIEVEMENTS

Bangladesh has made remarkable development progress over the last decade, with rapid increases in literacy and life expectancy at birth, expanded child immunization resulting in over 90% coverage, a continued decline in infant and child mortality, and a sharp decline of maternal mortality ratio (MMR) to 194 deaths per 100,000 live births (see Exhibit 1). The 2011 MDG Report rightly applauded Bangladesh's noteworthy progress in achieving MDGs 3, 4, and 5 (UN, 2013). In terms of health services delivery, antenatal care visits for pregnant women by medically trained providers increased from 33% in 1999-2000 to 55% in 2011, and deliveries performed by medically trained providers went from 12% to 32% during the same period. This increase in deliveries accompanied by skilled personnel was predominantly due to a rise in facility deliveries, which went from 8% to 29% from 1999-2011 (National Institute for Population Research and Training, 2011).

Bangladesh also demonstrated substantial progress in implementing an effective family planning program. Bangladesh is well known for its strong Government commitment and civil society support resulting in notable progress over the years in expanding and strengthening its National Family Planning (FP) Program. The Health, Population and Nutrition Sector Development Program Strategy (HPNSDP) 2011-2016 from the Ministry of Health and Family Welfare (MOHFW) clearly demonstrates this strong commitment to its strategies, program components and activities, and budget for the national family planning program. The decline in total fertility rate (TFR) and increase in contraceptive prevalence rate (CPR) is commendable. The reduction in the TFR from 6.3 births per woman in 1975 to 3.4 in 1994, and further decline to the current rate of 2.3 in 2011 (NIPORT, 2011) is expected to lead Bangladesh to reach the fertility level of 2.0 children per woman by 2016 (see Exhibit 2). The increase in skilled delivery, coupled with the reduction in fertility, has resulted in a 40% reduction in the MMR from 320 in 2001 to 194 in 2010 (NIPORT, 2011).

Gradual improvement in basic health and nutrition services also contributed to a substantial reduction of the under-five mortality rate (from 94 deaths per 1000 live births in 1999-2000 to 53 in 2011) (see Exhibit 3), an accomplishment for which Bangladesh received the United Nations MDG Award in 2010.

EVOLUTION AND GROWTH OF PRIMARY HEALTH CARE AS AN INTEGRATED HEALTH SYSTEM

In 1973, the executive board of the World Health Organization (WHO) recommended a strategy to respond to the need for basic health services. This strategy was the foundation for the Alma-Ata declaration on Primary Health Care in 1978. The declaration advanced from merely administrative coordination of health services to a health systems perspective, which emphasized the interrelationship of all the components of a system, including the individual, family, and community (WHO, 2008).

The main intended outcomes of integration listed by WHO are improved efficiency, increased quality of health services, and better health status overall. It is expected that a wider range of services can be offered through integration, thus reducing differences in access and utilization of health services between geographic and socio-economic groups, leading to greater equity (WHO, 1996). This increased convenience for health service users leads to their increased satisfaction. Satisfied clients are more likely to access services when in need, and adhere to treatment plans and preventive measures recommended by health care providers. Integrated services are more likely to improve health overall, while ensuring long-term sustainability than vertical programs (see Exhibit 4; WHO 1996). This integrated strategy informed the development of primary health care services in Bangladesh.

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ADVANTAGES OF PROVIDING FP-MNCH TOGETHER

Integrating FP and MNCH services typically means offering women a broad set of family planning and maternal and child health services during the same appointment, at the same service delivery site, and from the same provider. WHO focuses on integrated health services as a way for people to “get the care they need, when they need it, in ways that are user-friendly, achieve the desired results, and provide value for money.” By accessing FP and MNCH services together, women are able to use their time efficiently and productively. The following are ways in which integrated FP-MNCH services improve maternal health status and reduce child mortality (Population Reference Bureau, 2011):

- *Lengthening the interval between pregnancies:* One rigorous study, based on over 1 million births, found that if all women waited 36 months after a live birth before becoming pregnant again, the deaths of an estimated 1.8 million children under 5 years of age would be prevented.
- *Reducing the number of high-risk pregnancies:* Helping women avoid pregnancies that occur too frequently, or too early or late in life, reduces deaths and disabilities among women and children, and saves health and social service expenditures.
- *Ensuring health services are offered in an efficient and cost-effective way:* Numerous costing studies have demonstrated that a single, multipurpose FP-MNCH visit can save the health system money by using common space, reducing staff costs, and lowering overhead. Broadening skills of personnel helps ease the shortage of health workers.
- *Improving women’s lives and satisfaction with services:* When women obtain different types of care in one visit, they reduce the travel time and expenses of multiple visits and have more time to be productive.

Some countries have found that the path to economic growth and development is enhanced by providing family planning (FP) together with maternal, newborn, and child health (MNCH) care. This integrated approach covers the spectrum of health services women seek for themselves (before, during, and after pregnancy) and for their children. Offering these services together is a cost-effective way to prevent unintended pregnancy while providing other needed health services for a large number of women, thereby contributing to a healthier population overall (Population Reference Bureau, 2011).

BANGLADESH GOVERNMENT’S EFFORT IN INTEGRATION OF SERVICES

The 2013 Lancet Series on Bangladesh identified factors for health sector successes in Bangladesh including engagement of various stakeholders (i.e. government and non-governmental organizations), and having women-focused, equity-oriented, and nationally targeted integrated programs. Among all other approaches, the Government of Bangladesh has prioritized the provision of integrated services to women and children (Chowdhury et al., 2013). The integration of services gained momentum in 1997 as a strategy for deriving greater impact from health resources and systems including cost-effective use of limited resources, streamlined care for patients, increased reach and efficiency of health programs and services, and improved funding for the health sector. Bangladesh offered integrated services to its citizens both through grass-roots level health clinics and employing female health workers trained in delivering integrated services at the household level.

In Bangladesh, integration is aimed at improving service in relation to efficiency and quality, thereby maximizing use of resources and opportunities. A primary health care unit in Bangladesh is expected to be able to: provide preventive care (using staff, procedures, and drugs); deliver vaccines (with effective cold chains, immunization schedules, and information

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systems to ensure coverage); scale-up high-impact interventions (to reduce maternal and child deaths through pre-natal and post-natal services); and provide reproductive health services (requiring expertise in family planning methods, skills in advising people, treatment of sexually transmitted diseases, and provision of effective follow up). The primary health care services in Bangladesh, both preventive and curative, are delivered in a package called the “Essential Services Package (ESP)”. Strategies to promote integration include managing the services together to maximize efficiency, and delivering services together, to increase service access and quality.

The Bangladesh Government, as well as the country’s Non-Governmental Organization (NGO) sector, prioritized the availability of integrated services for women and children at all levels of the health system in order to achieve their primary goals in the health sector. Strategies that have allowed these sectors to develop integrated health services include planning and budgeting, organization of health services, staffing, training, supervision, and logistics.

Bangladesh’s Ministry of Health and Family Welfare (MOHFW) is responsible for the implementation, management, coordination, and regulation of national health and family planning related activities, programs, and policies. The Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) are the two main service-providing agencies, through which MOHFW implements its programs.

There have been several attempts to unify DGHS and DGFP to provide integrated services at the field level. While this unification has not occurred at the central level, functional integration has occurred at the field implementation level. At the central level, FP and general health commodities (i.e. vaccines, life-saving drugs, and contraceptives) are being managed by two different directorates. Management Information Systems (MIS) are also being used in a fragmented way, resulting in duplication in several respects. Under the Program Implementation Plan (PIP) of the MOHFW sector program (Health, Population, Nutrition Sector Development Program - HPNSDP), there are 32 separate Operational Plans (OP) of which two different OPs include Maternal Neonatal Child, Adolescent, and Reproductive Health (MNCARH) components under two different directorates. Service providers from two directorates are considered to be separate cadres and provide services from separate outlets affiliated with either DGFP or DGHS.

The Bangladesh government has established Community Clinics at the village level to extend primary health care to the doorstep of rural people all over Bangladesh. These community clinics (one per 6,000 population) provide integrated primary health care through a range of services including health education (on health, nutrition, and FP), health promotion, treatment of minor ailments, supply of FP commodities, first aid, ANC (Antenatal Care), PNC (Postnatal Care), and identification of emergency and complicated cases that will be transferred through an effective referral linkage with higher facilities (i.e., Union Health and Family Welfare Center [UH and FWC] and Upazila Health Complex [UHC]) for better management.

Though integration has not been fully accomplished at the central and policy level, at the field implementation level functionally integrated services are available to address the needs of the target population. A Family Welfare Visitor (FWV) provides a wide range of family planning and maternal health services from UH and FWC and a Sub-assistant Community Medical Officer (SACMO) provides child health services and treatment for common ailments. The Upazila Health Complexes (UHCs) and District Hospitals (DHs) offer a wide range of services in a more integrated fashion. Considering the structure and mode of service delivery on the ground, it can be stated that successful functional integration has been possible in Bangladesh despite the

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structurally bifurcated directorates at the central level. This integration has ensured improved access, equity, and service effectiveness.

Moreover, the Bangladesh Government fosters a culture of partnership in achieving health sector goals. To complement the Bangladesh Government's primary health care programs, NGOs are invited to participate in service delivery. By virtue of more decentralized policy and planning practices of NGOs, it is easier for them to design and implement integrated services. More recently, the private sector has also been an active partner in the health sector. Both NGOs and the private sector benefit from autonomy within a regulatory framework set by the government.

USAID'S RESPONSE TO BANGLADESH'S HEALTH SECTOR PRIORITIES

Evolution of an Integrated Service Delivery Project: Smiling Sun Network

Historically, USAID has provided financial and technical support to NGOs in the health sector to complement the Bangladesh Government's overall plan and to participate in health programming. As a part of the agreement with the Bangladesh Government, USAID launched two NGO-supported projects: the Rural Service Delivery Project (RSDP) and the Urban Family Health Partnership (UFHP) in 1997. The primary purpose of these projects was to improve the service delivery of health and population programs by providing integrated services with a client-centered approach. In an effort to better integrate and manage the health and population services provided by NGOs, the NGO Service Delivery Project (NSDP) was created in 2002 by uniting RSDP and UFHP. Subsequent to NSDP, USAID launched the Bangladesh Smiling Sun Franchise Program (SSFP) in 2007, which collaborated with a network of 26 NGOs to provide high-quality health services. In 2012, the current service delivery project (NGO Health Service Delivery Program) was launched continuing the objective of making integrated services available through 334 static clinics widely known as Smiling Sun clinics and 10,000 satellite sessions in all 64 districts.

For the past 17 years, the USAID Bangladesh Mission (USAID/B) has contributed to the largest investment in the health sector by responding to the Government of Bangladesh's (GOB) priorities. The package of services that has been provided through the network of Smiling Sun clinics is GOB's "Essential Services Package (ESP)." While designing these projects, USAID/B ensured that the clinics served as one-stop service centers offering a continuum of care. Every effort has been employed to popularize these clinics for getting services for all family members. USAID/B worked to ensure that high impact interventions are delivered through an integrated service delivery model. Subsequent evaluation reports of these projects revealed that service contacts continuously increased from 1997 to 2011. Unlike the GOB, the project is using a unified Management Information System and central procurement to ensure all commodities are available at the service delivery points.

Evaluation reports from the service delivery projects have covered almost all of the key outcome areas, especially coverage and access, service use and uptake, and equity. Evaluations have been designed based on the projects' specific objectives, thus, some outcomes regarding integrated service perspectives were not measured. For almost all services, uptake has increased over time, as has the range of services offered by those clinics. Family planning service has always been a priority for Smiling Sun clinics (Lance, Angeles, & Kamal, 2012). Different components of maternal health services, child health services, and communicable diseases have been added with time. For example, ANC and PNC were major services available from Smiling Sun clinics from 1997, but Emergency Obstetric Care (EmOC) was added in response to client needs; currently 56 clinics have been providing EmOC services in

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the Smiling Sun clinics network. Doctors and Paramedics are the service providers at the static and satellite clinic level. Community Service Providers (CSPs) provide non-clinical family planning services and commodities, as well as Community-Integrated Management of Childhood Illness (C-IMCI) for children at their homes. Responding to the cultural preference of women wanting to deliver at home, Smiling Sun clinics also designed a community skilled birth attendants program to ensure skilled attendance at home births. The project has always taken a client-centered approach to ensure client satisfaction and better reach.

Other unique approaches that the project followed are engagement of the private sector, identification and prioritization of population sub-groups from lower quintiles to address equity issues, setting-up a rigorous quality assurance process, and an inclusive monitoring and evaluation system.

MaMoni: Integrated Safe Motherhood, Infant Care, and Nutrition Project

The MaMoni project was implemented from 2009 to 2013 through the Maternal and Child Health Integrated Program (MCHIP). The design of the project was based on the findings and experiences from a randomized controlled trial known as Projahnmo (2001-2006) and ACCESS (2006-2009). MaMoni aimed to increase the use of high-impact maternal and newborn health (MNH) behaviours, including family planning, and to strengthen the Ministry of Health and Family Welfare (MOH and FW) systems to provide quality FP-MNCH services. The project worked in two under-performing districts in Bangladesh. With the progression of the project, many components have been added to integrate services to meet client needs. During the Projahnmo project period, the only focus was on newborn health, while the ACCESS phase included FP and MNCH components. The current phase of the project, launched in 2012, named MaMoni-Health Systems Strengthening (HSS), includes HSS components with service delivery options and scaling-up evidence-based interventions such as Antenatal Corticosteroids (ACS), Chlorhexidine (CHX), antibiotics to manage newborn infection, MagSo4, Misoprostol, etc. MaMoni also successfully implemented task shifting and customized district planning in the Government of Bangladesh's service delivery centers.

The overall objective of MaMoni is “increased and sustained practice of high impact maternal and neonatal behaviors and use of services during the antenatal, childbirth, and postnatal periods, including increased use of modern family planning methods.” During the planning and implementation phases, MaMoni focused on both technical integration and functional integration among existing structures (see Exhibit 5).

For the technical integration, the project focused on continuum of care. As soon as a pregnancy was identified in the community, the mother was entitled and enrolled for all FPMNCH-N interventions as per her pregnancy and post-pregnancy health needs, until the child's first birthday (see Exhibit 6).

The achievements of the project were demonstrated by increased use of antenatal care (ANC), deliveries with a skilled birth attendant, referrals for complications, PNC, and FP, including long-acting and permanent methods (LAPM). The evaluation results showed that:

- Deliveries in the upgraded Family Welfare Centers have significantly increased, as evidenced by more than 50% of all the deliveries in the seven unions being attended by skilled attendants and the majority of deliveries taking place at upgraded facilities. In addition, private Community Skilled Birth Attendants conducted 38% of all the deliveries in the very remote areas where no other trained providers were available;

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- MaMoni developed an extensive system for referral from the village to the District Hospitals (DH). As a result, there has been a six fold increase in maternal referrals to the DH as well as increased newborn referrals; and
- There has been a modest increase in use of injectables. LAPM uptake has been sporadic, due to a reliance on availability of trained service providers, but the average monthly case-load has increased.

The data indicate that MaMoni has been very successful, resulting in significant increases in the use of key MNCH services and exceeding many projected targets (USAID, 2013).

An Operations Research: Healthy Fertility Study (HFS)

USAID/B launched a program of “operations research to address unmet need for contraception in the postpartum period in Sylhet District, Bangladesh” in 2007, also known as the “Healthy Fertility Study (HFS)”. The study developed and tested an integrated FP-MNCH service delivery approach in the rural settings of Bangladesh. It also assessed the strengths and limitations of integrating FP into an ongoing community-based MNH care program.

Under the study, the effectiveness of FP-MNCH integration was assessed in three critical ways: 1) use of contraceptives; 2) impact on birth spacing behaviours; and 3) impact of HFS activities on newborn care practices. The study enrolled 4,505 pregnant women and followed them for 36 months post-partum. The study findings demonstrated effectiveness of the interventions in following ways:

- **Contraceptive Use**
HFS activities were associated with a 27% increase in contraceptive uptake in the intervention arm from 18% at baseline to 45% at 36 months postpartum.
- **Birth-to-pregnancy Intervals**
During the 36 months of postpartum observation, HFS activities were associated with a 21% reduction in the cumulative probability of postpartum pregnancy after the delivery of the index child. Findings indicate that by 36 months postpartum, 47% of women in the intervention area became pregnant compared to 56% in the control area. In addition to significant declines in pregnancy incidence, the hazards of shorter birth intervals were reduced by 21%.
- **Health Impact**
A major concern of an integrated health program is that the process may overload the health workers with added tasks that may compromise the performance of health workers and thus adversely affect the main program. As part of the efforts to evaluate the adverse effects of integration, data analyses sought to determine the differences in neonatal and infant mortality rates. The neonatal mortality rates (deaths within 28 days of birth per 1,000 live births) were not significantly different by study arm (37 per 1,000 live births in the intervention area versus 35 in the control area) and as such, no adverse consequences on health impact were observed. The study also examined the positive impact of FP integration with the MNCH program by the difference in pre-term and Low Birth Weight (LBW) of subsequent births. Findings suggested that odds of preterm birth outcomes were 20% lower in the intervention area compared to the control area, but the finding was marginally significant. Among contraceptive methods, Lactational Amenorrhoea Method (LAM) was an important method of contraception at three and six months postpartum in the

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intervention area. Breastfeeding practices were improved because of the introduction of LAM.

- **Feasibility**

Study findings suggest that the integration of FP services into a community-based MNH service delivery platform is feasible and effective without undermining or reducing coverage of MNH interventions. The overall coverage remained high in both intervention and control areas, exceeding 70% for the majority of visits. Finally, coverage for the additional HFS postpartum visits at months two or three and four or five was 63% and 73%, respectively.

The findings of this operations research demonstrated that integration of services is possible even at the community level and that integrated services ensure broader and positive health outcomes (USAID, 2012). These findings have been used in designing other projects under the Office of Population, Health, Nutrition and Education portfolio.

Overall Achievements of USAID-Funded (Exhibit 7) Integrated Projects

Evaluations were conducted for all phases of the Smiling Sun project and MaMoni. The results demonstrated that the projects were successful in:

- Expanding access to and coverage of services per client contact;
- Increasing use of services and improved behavioural outcomes;
- Decreasing costs per visit or per service, and increased cost-effectiveness;
- Guaranteeing more timely and improved quality and continuity of services delivered, resulting in better patient care;
- Ensuring more family-centered care responsive to multiple client needs leading to greater provider and client satisfaction with services;
- Confirming more efficient use of existing resources by reducing fragmentation and duplication; and
- Ensuring improved equity and increased sustainability of effects through improved health system strengthening.

LESSONS LEARNED FROM INTEGRATION IN USAID-SUPPORTED PROJECTS IN BANGLADESH

These lessons are pulled from decades of experience in implementing integrated service delivery projects in Bangladesh as well as evaluations and project reports:

- **Country Ownership and Government's Endorsement:** Despite a huge population to serve with limited resources, the Bangladesh Government remained focused on ensuring health services are available for all. The GOB put tremendous effort into establishing a network of service delivery outlets for both urban and rural areas. Historically, the GOB worked very closely with development partners while designing and implementing health strategies. The GOB recognized and valued the contributions that the NGO and private sector made to achieve overall health goals. In the five-year sector development program (2011-2016), the GOB clearly identified the contributions of NGOs and the private sector, including in the annual program reviews (Government of the People's Republic of Bangladesh, 2011). Through documented strategic directions, guidelines, and accountability for reporting, the GOB helps NGOs and the private sector excel in their performance. USAID-supported NGO programs were not an exception (HPNSDP and Annual Program Review (APR)).

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- **Partnership and Coordination:** There is a strong partnership within the development community in Bangladesh, fully committed to supporting the MOHFW's health development programs that focus on goals, including the health-related MDGs. In line with the "Paris Declaration on Aid Effectiveness, 2005", efforts are being made in the country to harmonize donor support and its alignment with national plans and strategies. Coordination mechanisms, such as the Local Consultative Group (LCG) and the HPNPSP Consortium, as well as specific Steering Committees in some areas, are in place to improve aid effectiveness. The assistance from the development partners over the last decade has consistently been in the range of 30% to 40% of the health, nutrition, and population sector expenditure. USAID invests in the Bangladesh Health Sector Program through Development Objective Agreement (DOAG) and a Single Donor Trust Fund and plays a leadership role in LCG.

Effective coordination and collaboration was fostered among Governments and the private sectors. USAID/B has maintained a stable relationship with the GoB and through its projects has coordinated with the private sector. The Smiling Sun network created partnerships with pharmaceutical companies, cell phone companies, banks, and many others to expand their services to the hard-to-reach population. The MaMoni project partnered with private sector agencies like Unilever, Laredal Foundation, Venture Strategies Innovation (VSI), Korean Broadcasting Agency, and other donor and professional associations, to maximize the output of the project.

- **Leadership and Policy Support:** The Government of Bangladesh has been an active partner in planning and implementing USAID/B's development programs. USAID's new Country Development Cooperation Strategy (CDCS) for Bangladesh follows in the tradition of partnership. Over the next five years, USAID will support the GOB's plans to transform its economy to achieve Bangladesh's ambitious vision of becoming a middle income country by 2021. The results framework of Development Objective 3 (DO3) reflects the logical relationship of USAID/B's efforts to increase access to quality health services while strengthening health systems. DO3's development hypothesis is: If all Bangladeshis have access to quality health services at an affordable cost and are aware of the benefits of using these services, they will use these services, leading to improved health outcomes. Strengthened health systems are integral to ensuring access to quality and sustainable service provision. USAID/BCDCS is based on Government of Bangladesh designed national plans, including the Sixth Five-Year Plan for 2011–2015.
- **Continuity:** A tradition of follow-up activities have been observed over the past few decades for USAID/B. Projects were closely followed-up and monitored for effective implementation and achievement of desired goals. Whenever follow-up projects were designed, gaps were scrutinized and a critical analysis of challenges faced by the predecessor project was conducted. USAID/B was also always responsive to the host government's direction and needs. As examples, the mission's current service delivery and health systems strengthening projects evolved from separate initiatives into integrated service delivery projects.
- **Availability of Funds:** The Health Population and Nutrition Sector Development Program (HPNSDP) has been initiated by the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh for a period of five years, from July 2011 to June 2016. The total estimated budget for the sector program is \$7.7 billion, with the Government's contribution at 76% and the Development Partner's contribution at 24%. The GOB's commitment to improve the health status of the citizens is clearly reflected in the budget. In terms of USAID-

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supported projects, historically both MCH (Maternal and Child Health) and FPRH funds were available and have increased for Bangladesh over the past two decades.

- **Continuum of Care:** USAID-funded projects in Bangladesh always focused on ensuring the continuum of care for the targeted population to ensure better health outcomes. Continuum of care is ensured through service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood. Services are provided for families and communities, through outpatient services, clinics and other health facilities. MaMoni's integrated model (Exhibit 6) is completely aligned with the WHO model of integration (Exhibit 8).
- **Local Adaptation of Integration Model:** Integration has been defined as “the organization, coordination, and management of multiple activities and resources to ensure the delivery of more efficient and coherent services in relation to cost, output, impact, and use (acceptability)” (USAID, n.d.). While designing and implementing project activities, several adjustments have been made in USAID-funded projects to comply with country policy and to satisfy local needs. The flexibility supported the achievement of better results from the integrated projects. In the Smiling Sun network, services were added over time, (e.g. maternal health, child health, and communicable disease services with family planning) to make it more integrated. Through changes made in different phases of the MaMoni and HSS project, the project's current evolution supports FP-MNCH-N (Nutrition) services delivered in primary health care centers. Findings and lessons learned from Healthy Fertility Study (HFS) were adopted both by Smiling Sun network and MaMoni projects.
- **Data-based Decision Making:** USAID/B carefully examined results of impact evaluation prior to project design, recognizing its integral part of the planning process. Concrete efforts are taken by projects to strengthen the Health Management Information System (HMIS) and build capacity of the MOHFW managers to ensure the availability and analytics use of real time data in planning. The mission has a monitoring and evaluation advisor dedicated to the Office of Population, Health, Nutrition and Education, who has fostered the capacity of project managers to ensure data quality and use for decision-making. Demographic Health Surveys have been conducted regularly in intervals of three years, which served as the basis of project planning and prioritization.

The 24 EPCMD priority countries can also advance support for FP-MNCH integration by considering the following aspects:

- Evidence suggests that offering FP and MNCH services together saves money and can address health needs. With the aim of providing integrated services, countries need to support additional training for workers and volunteers, as well as adapt health facilities to provide services in an integrated fashion.
- Assessment of current systems is another essential element of providing integrated services. Shifting to integrated services requires careful planning and assessment of the costs and other resources such as changes in policies, training, supervision, management, logistics, and management information systems.
- In terms of scarcity of service providers, especially in rural and hard-to-reach areas, task shifting can help achieve the project goals of making services accessible to the target population.
- It was evident that working with the private sector and NGOs to expand access to health services was successful in different countries, including in Bangladesh.

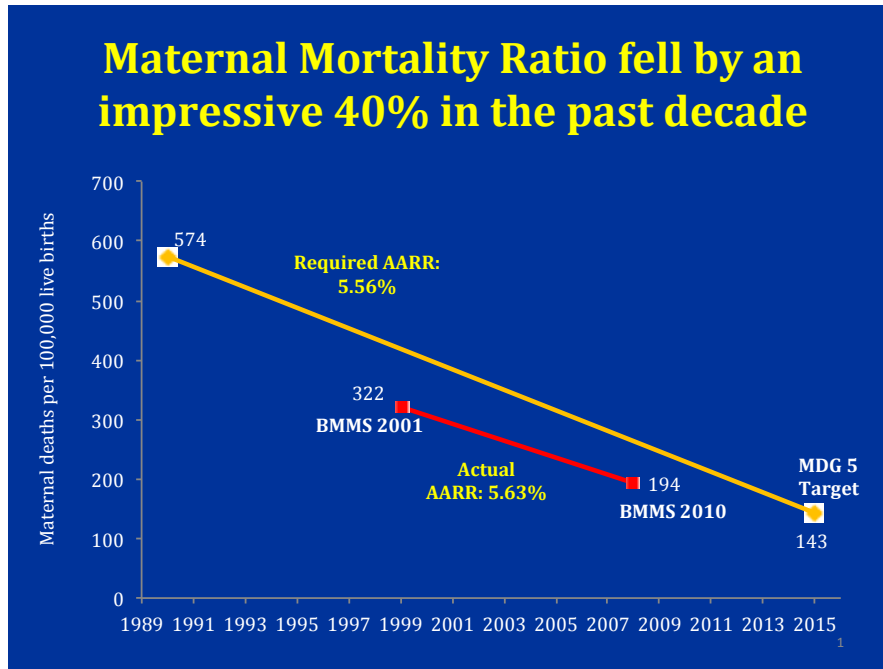
Integration of FP-MNCH Services to Accelerate Reduction of Maternal & Child Deaths: Bangladesh Experience

- Globally, women and children from lower wealth quintiles are less likely to access services compared to their wealthier counterparts. Integrated programs need to be designed to address cost barriers to ensure equity.
- Integrated projects require appropriate indicators for tracking implementation and evaluating the impacts of integrated services.

To achieve EPCMD goals, one strategy that countries can follow based on the Bangladesh example is to implement integrated services to reach women and children. In that case, countries need to ask the following key questions for designing effective models of integrated services:

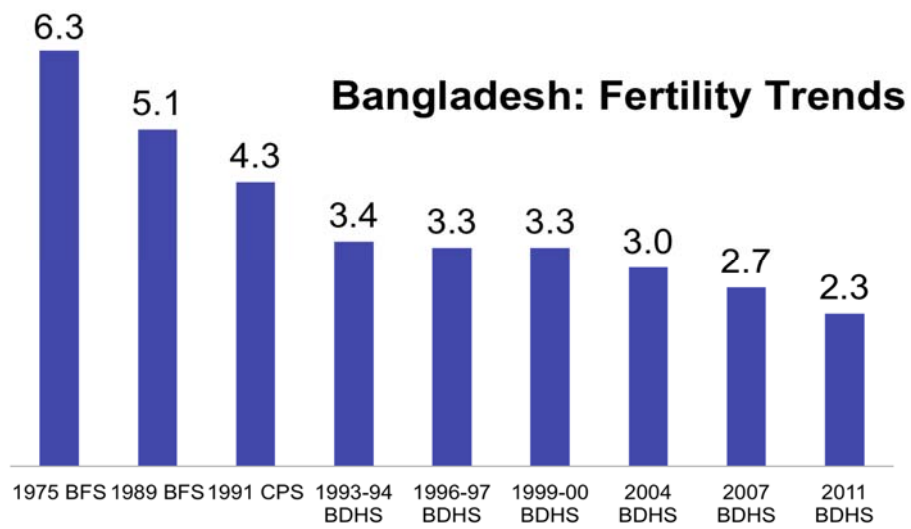
- To what extent is a supportive policy environment in place to facilitate integration?
- To what extent are programs being consolidated to achieve better outcomes at lower cost?
- To what extent are health system support strategies being managed to support integrated service delivery and healthy behaviours in the home?
- To what extent have services been integrated to expand access, improve quality, lower costs, and respond to client needs?
- To what extent are families adopting healthy behaviours to safeguard their well-being and improve their quality of life?

EXHIBIT 1
Maternal Mortality Reduction in Bangladesh



Data Source: NIPORT, 2010; graph created by author.

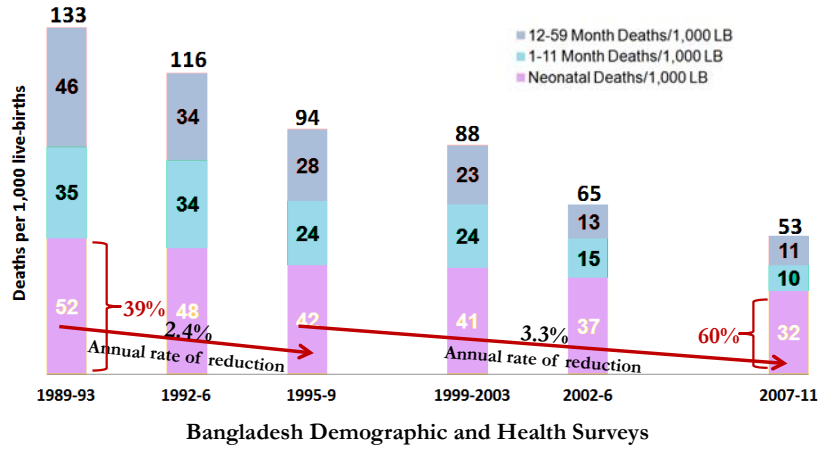
EXHIBIT 2
Fertility Trends in Bangladesh



Source: NIPORT, 2011, pg. 64.

EXHIBIT 3
Under-5 Mortality Rates, Bangladesh

Bangladesh on track to achieve MDG4 targets well before 2015



Data Source: NIPORT, 2011; graph created by author.

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EXHIBIT 4

**Advantages and Disadvantages of Integrated Health Services
WHO Technical Report on Integration of Health Care Delivery, 1996**

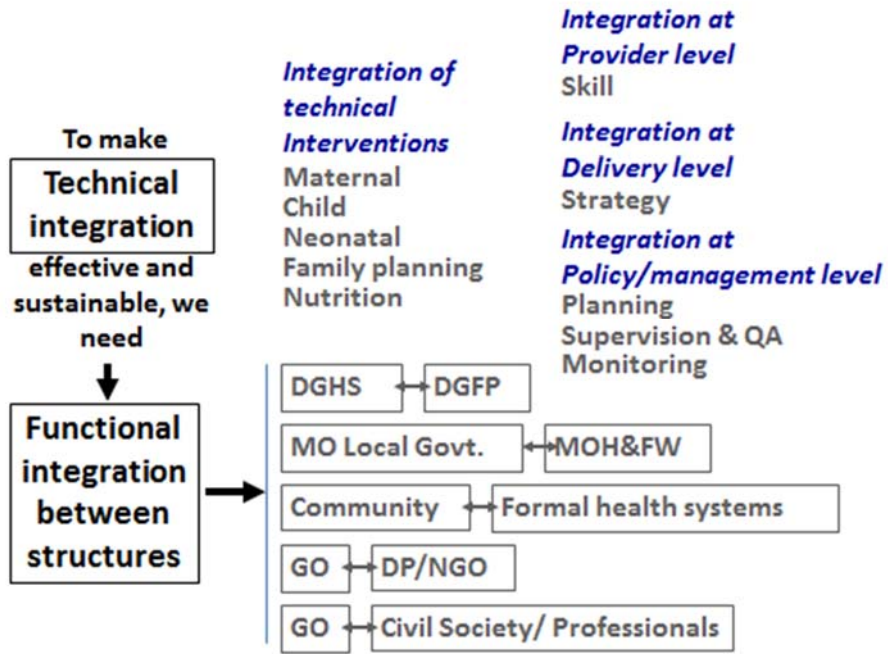
Advantages	Disadvantages
<ul style="list-style-type: none"> • Allows delivery of a range of services selected to suit national health policies and local needs • Incorporates inputs from different components of health systems and thus reflects the multidimensional concept of health. • Has the capacity to take on new activities and react to disasters. • Allows multi-purpose use of resources, such as personnel and allows more outputs to be achieved for a given input. • Allows planning and management of health services according to local circumstances with appropriate political, intersectoral and community involvement. • Makes it easier to respond to user needs, which saves time, and encourages personalized service and continuity of care and thus increases convenience and user satisfaction. • Allows a more holistic approach to health, centred on the health needs of individuals and communities. 	<ul style="list-style-type: none"> • May fail to set appropriate priorities. • May fail to adopt a programming approach, with clearly defined objectives, targets, operational planning and monitoring by outputs/outcomes. • May fail to achieve the levels of output and impact in key health care areas that would be reached by single-purpose programs. • May cause uncertainty and dissatisfaction among health service employees if adequate explanations and reassurances are not given.

Source: WHO, 1996, p. 6.

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EXHIBIT 5

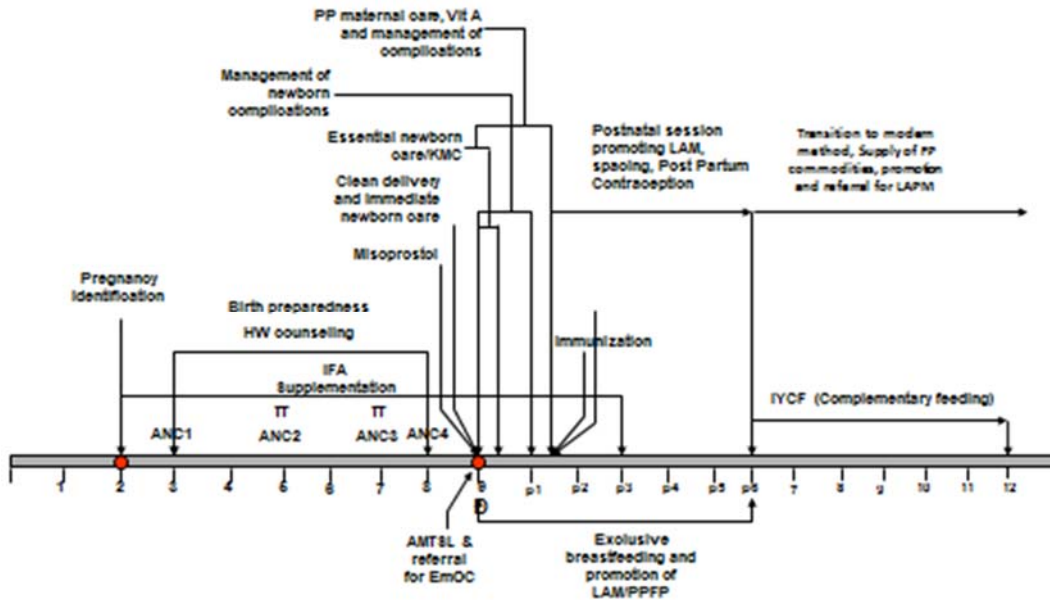
Functional and Technical Integration of Services in MaMoni Project Area



Source: USAID.

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EXHIBIT 6 Continuum of Care Model in MaMoni Project



Source: USAID.

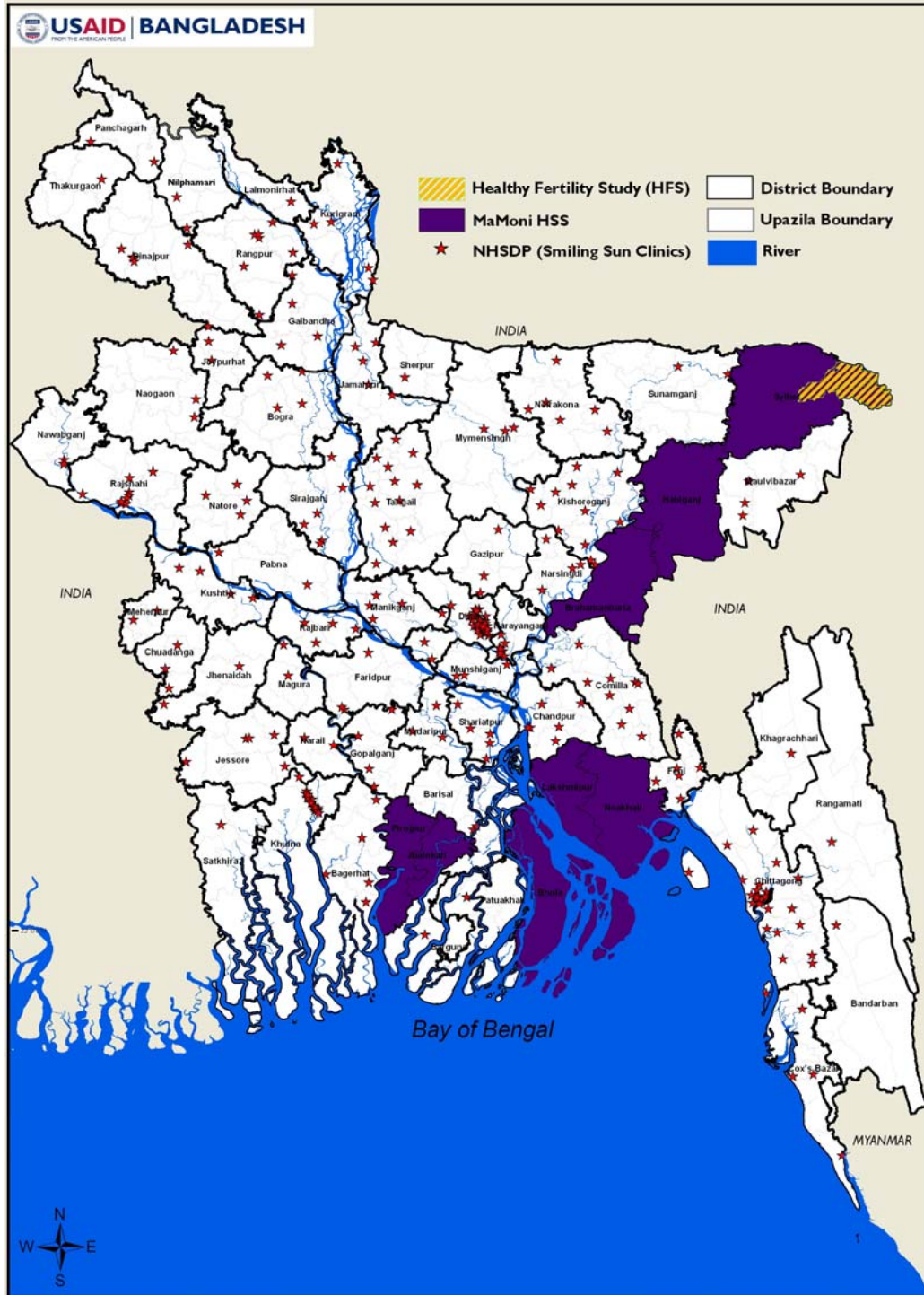
Essential Services Package (ESP)

Government of Bangladesh's ESP focused on primary care interventions which could most cost effectively reduce the burden of disease in Bangladesh, and included services in 4 main categories: child health, reproductive health, communicable disease control and limited curative care.

Offering those services meant that customers received all the services they need in one place, at a slightly reduced price, and helped the clinics become more sustainable.

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EXHIBIT 7 USAID-Funded Projects (three major projects are shown in the map)



Source: USAID.

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EXHIBIT 8
Continuum of Care Model



Source: WHO, 2011, p. 24.

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INSTRUCTOR GUIDANCE

Integration of FP-MNCH Services to Accelerate Reduction of Maternal and Child Deaths: Bangladesh Experience¹

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BACKGROUND

Women and children are still dying in alarming numbers from preventable causes. A child born in a low-income country is approximately 18 times more likely to die before the age of 5 than a child born in a developed country. Over a lifetime, a woman's risk of dying as a result of pregnancy and child-birth in a low-income country is over 40 times higher than in the United States. Ending Preventable Child and Maternal Deaths (EPCMD) by 2035 is one of United States Agency for International Development's (USAID) top priority health initiatives. Currently, USAID invests 90 percent of its maternal and child resources in the 24 countries that account for 70 percent of maternal and child deaths in the developing world. Bangladesh has made remarkable development progress over the last decade, achieving a sharp decline of maternal mortality ratio (MMR). This case examines the initiatives in Bangladesh to see how they can inform strategies for the other priority countries where USAID is making significant investments in maternal, newborn child health (MNCH).

OBJECTIVES

1. Explore models for integrated services in a resource poor country.
2. Assess MNCH strategies adopted in Bangladesh to inform initiatives in other nations.
3. Examine policy frameworks to identify support for integrated MNCH.

DISCUSSION QUESTIONS

1. To what extent is a supportive policy environment in place to facilitate integration?
2. To what extent are programs being consolidated to achieve better outcomes at lower cost?
3. To what extent are health system support strategies being managed to support integrated service delivery and healthy behaviors in the home?
4. To what extent have services been integrated to expand access, improve quality, lower costs, and respond to client needs?
5. To what extent are families adopting healthy behaviors to safeguard their well-being and improve their quality of life?

KEYWORDS

Bangladesh; maternal, newborn child health; family planning; service integration; Millennium development goals.

¹ The contents are the responsibility of authors and do not necessarily reflect the views of USAID or the United States Government. All information found herein is available in publicly accessible materials.