# Schedule and brief for Field Trips

**To sign up for one of the field trips, please contact**
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**Schedule of field visit in *Manoshi* (urban maternal, neonatal and child health project funded by Bill and Melinda Gates Foundation) for PMNCH Board Members**

Date: 28.04.10 (Wednesday)

**Group: 1 (Korail)**

| Date | Time | Event | Venue |
|---|---|---|---|
| 28.04.10 | 1.00pm | • Starting for field visit from BRAC Centre | |
| | 1.15pm – 2.00pm | • Visit BRAC Delivery Center<br>• Meet Urban Birth Attendants and Manoshi Midwives<br>• Observe meeting with expectant mothers | Delivery centre |
| | 2.00pm – 2.45pm | • Meet *Shasthya Kormi* and *Shasthya Shebika* providing ANC to a pregnant women<br>• Meet recently delivered mother and neonate<br>• Meet women referred to hospital for maternal complications | Slum |
| | 2.45pm – 3.00pm | • Return back | |

**Group: 2 (Shat tala)**

| Date | Time | Event | Venue |
|---|---|---|---|
| 28.04.10 | 1.00pm | • Starting for field visit from BRAC Centre | |
| | 1.15pm – 2.00pm | • Visit BRAC Delivery Center<br>• Meet Urban Birth Attendants and Manoshi Midwives<br>• Observe meeting with expectant mothers | Delivery centre |
| | 2.00pm – 2.45pm | • Meet *Shasthya Kormi* and *Shasthya Shebika* providing ANC to a pregnant women<br>• Meet recently delivered mother and neonate<br>• Meet women referred to hospital for maternal complications | Slum |
| | 2.45pm – 3.00pm | • Return back | |

**Group: 3 (Kunipara)**

| Date | Time | Event | Venue |
|---|---|---|---|
| 28.04.10 | 1.00pm | • Starting for field visit from BRAC Centre | |
| | 1.15pm – 2.00pm | • Visit BRAC Delivery Center<br>• Meet Urban Birth Attendants and Manoshi Midwives<br>• Observe meeting with expectant mothers | Delivery centre |
| | 2.00pm – 2.45pm | • Meet *Shasthya Kormi* and *Shasthya Shebika* providing ANC to a pregnant women<br>• Meet recently delivered mother and neonate<br>• Meet women referred to hospital for maternal complications | Slum |
| | 2.45pm – 3.00pm | • Return back | |

# A Brief Note on the Manoshi-Urban MNCH Project

**TITLE OF THE PROJECT:** Manoshi

**PROJECT DURATION:** Jan 01, 2007 - Dec 31, 2011

**GOAL:** Decrease illness and death in mothers, newborns, and children in urban slums in Bangladesh through the development and delivery of an integrated, community-based package of essential health services.

## SPECIFIC OBJECTIVES

- Increase knowledge of individuals, households and community;
- Increase skills and motivation of human resources to offer services at household and community levels;
- Enhance and strengthen referral linkages;
- Strengthen and sustain referral linkage with local government and government health facilities;
- Involve all stakeholders and strengthen their capacities to effectively participate in all stages of the programme;
- Develop a supportive network to support communities and individual households to sustain the services;
- Increase demand of services; and
- Facilitate scaling up of successful approaches.

## SERVICE PACKAGE

- Trained community health workers to provide key preventive and curative services at the household level.
- The community health worker provides basic, community-based maternal health, neonatal and child health care services.
- Timely referral systems to triage obstetric emergencies and other severe acute illnesses in women, newborns, and children to care at qualified health facilities.
- Women's education and empowerment groups to organize urban slum communities around key health and nutrition issues affecting mothers, newborns, and children.
- Linkage to existing municipal, NGO, and other local health services including hospitals and clinics operating in the community.

## COMMUNITY HEALTH WORKERS

The community health workers are selected from the community and local vicinity with the assistance of the BRAC Village Organization members, community and BRAC field staff. BRAC follows some criteria to select community health workers. The Shasthya Shebikas (SSs) are the frontline workers each covering 200 households (population of 1000). The Urban Birth Attendants (UBAs) are drawn from local TBAs. Two UBAs work in a birthing hut with 2000 households (population of 10,000). The Shasthya Kormis are the second frontline workers each supervising five SSs and one UBA in catchment of 2,000 households. In some areas, another cadre known as community midwife works at birthing hut providing skilled care during delivery. Their activities are supervised by the Programme Organizer and coordinated by the SK.

BRAC develops capacity of community health workers with the intent of reaching quality services at grassroots. The basic training of SSs and SKs on maternal, neonatal and child health is arranged for three weeks in local training centers run by Training Cell of BRAC Health Programme. The SKs also receive training in health

communications. The UBAs drawn from local TBAs are given training in birthing care and basic management and referral of complications for two weeks. Community midwives are selected from the existing midwives who have received training in Family Welfare Visitor (FWV) or Nursing-midwifery. Moreover, all the SSs are given refresher's training every month and SKs and UBAs every alternate months on MNCH issues.

## SERVICE PROVISION

There are different components of health services intended for improving maternal, neonatal and child health. They include:

| Maternal health | Neonatal health | Child health |
|---|---|---|
| **Community based care**<br>1. Self-care<br>2. Antenatal, intra-natal and postnatal care<br>3. Safe delivery practices<br>4. Use of misoprostol for PPH prevention<br>5. TT vaccine<br>6. Micro-nutrient supply: Iron-folic acid; Postpartum Vitamin A; Iodized salt<br>7. Family planning<br>8. Social communications and community empowerment | **Community based care**<br>1. Essential newborn care<br>2. Exclusive breast feeding<br>3. Postnatal care for neonates<br>4. Special care for LBW<br>5. Caring practices<br>6. Diagnosis and management of birth asphyxia<br>7. Diagnosis and referral of neonatal sepsis<br>8. Social communications and community empowerment | **Community based care**<br>1. Exclusive breastfeeding and complementary feeding<br>2. Immunization<br>3. Micro-nutrient supply: Vitamin A<br>4. Diagnosis and management of ARI and diarrhea<br>5. Diagnosis and management of severe malnutrition<br>6. Management of childhood TB<br>7. Water, sanitation and hygiene education<br>8. Social communications and community empowerment |
| **Facility based care**<br>9. Comprehensive emergency obstetric care | **Facility based care**<br>9. Neonatal sepsis and birth asphyxia management<br>10. Management of other birth complications | **Facility based care**<br>9. Severe ARI and diarrhea management<br>10. Management of severe malnutrition<br>11. Diagnosis of childhood TB 4. Management of other health problems |

## DELIVERY CENTRE

Simple clean delivery centers are established, for each 2,000 households (a population of 10,000), adhering to set standards of hygiene and run by UBAs/ Manoshi midwives. The proximity, standards of cleanliness, maintenance of privacy and assistance with normal deliveries are likely to make centers both popular and viable. This SS accompanies a birthing woman from her catchment area and participates in birth event. The Manoshi midwife is posted to supervise activities of UBAs. The UBA gives tablet misoprostol to mothers during third stage of labor. They do immediate management of hemorrhage and immediately refer complicated cases to referral facilities. Neonatal complications, such as, birth asphyxia are managed by SS and if serious, immediately referred to referral facilities. For low birth weight babies, mothers are taught how to provide kangaroo mother care to maintain body temperature and feeding. The birthing women are usually allowed to stay for 12 hours after the baby is born. A total of 426 Delivery Centers are functional at this moment.

In the baseline of 2007, more deliveries were taking place at home and less in delivery centers and hospitals. Over the years, a clear and steady shift in the place of delivery is observed, that is, more deliveries taking place in delivery centers and in the hospitals. In 2009, out of 20,847 deliveries 26% took place at home, 40% in delivery

centre and 34% in hospital or clinics in early 12 intervention areas (initiated in 2007). In 23 late intervention areas (initiated in 2008) out of 37,070, the pattern was 25%, 29% and 46% respectively.

## Referral of complications

Maternal, neonatal and child health complications are referred to government and private hospitals equipped with emergency care. As soon as UBA or SS or a family member identifies complications, they communicate with BRAC referral PO using mobile phone and also inform SK. The patient is taken immediately to a pre-selected referral center in a transport, which has also been pre-arranged. In hospitals, the PO helps ensure management of complications by directly communicating with hospital doctors and nurses.

## Community empowerment

BRAC facilitates social mobilization for MNCH through building community and stakeholder capacity as active partners in health improvement and strengthens the skills and competences of key implementing personnel through advocacy workshops, interpersonal communications with target populations, popular media (music, theatre and TV/radio) and printed media.

## Partnership and co-ordination

BRAC uses its convening capacity as a major player to link with government, NGO and private health facilities. It also includes stakeholders at different levels to form committees. They are made aware of MNCH issues. The committees are also held responsible for monitoring and accountability systems.

## Program Coverage

BRAC will reach eight million populations in six city corporations and 15 statistical metropolitan areas in five years.

## Implementing Partner: BRAC

## Source of Funding: Bill and Melinda Gates Foundation, USA

## Manoshi Budget: US$ 25 million over five years

*Table 1. Population coverage and possible sites over five years*

| | Year 1 | | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|---|
| | 6 month | 6 month | | | | |
| **Population** | 500,000 | 500,000 | 3 m<br>(2.5 m + 0.5 m) | 4 m<br>(2 m + 2 m) | 8 m<br>(5.5 m + 2.5 m) | 8 m |
| **Possible sites** | Dhaka CC<br>(500,000) | Dhaka CC<br>(500,000) | Dhaka CC<br>(2.5 m)<br>8 Dhaka SMA<br>(0.5 m) | 5 CCs<br>(2 m)<br>7 Dhaka SMA<br>(2 m) | All city CCs<br>(5.5 m)<br>15 Dhaka SMAs<br>(2.5 m) | All city CCs<br>(5.5 m)<br>Dhaka SMAs<br>(2.5 m) |