From Exclusion to Mainstream: Paradigm Shift Towards Maternal and Neo Natal Health In Hard To Reach Areas of Bangladesh: Best Practices of ESDO

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Abstract**—** In Bangladesh country context, Maternal and Neo Natal Health in Hard to Reach Areas still now a challenge. A positive development has already made in maternal and neo-natal health in general areas which have contributed a significant coverage but remaining hard to reach area is the major challenge. There is no specific model for addressing appropriately the issues, it should be demand driven, need based and effective integration with others program and finally with the proper leadership of Directorate of Health and collaboration with all relevant service providers can make effective sustainable way to Exclusion to Mainstream: Towards Maternal and Neo Natal Health in Hard to Reach Areas of Bangladesh. Through this article, illustrated some Best Practices on reducing health risks and enjoy a better health and sanitation status, which has been directly impacting extreme poor's livelihoods through Eco-Social Development Organization (ESDO) - a Bangladeshi NGO.

Keywords**—** *Exclusion, Hard to Reach Areas Maternal and Neo Natal Health.*

I. Introduction

ECO-Social Development Organization (ESDO) started its journey in 1988 with a noble wish to stand in solidarity with the poor and marginalized community of Bangladesh. Being a peoples' centered organization, ESDO envisioned for a society which will be free from inequality and injustice, a society where no child will cry from hunger and no life will be ruined by poverty. In our 23 years of relentless efforts to make this happen, we have broken new grounds and opened up new horizons. We have been tireless in our efforts to help the disadvantaged and vulnerable people find a way to support themselves and bring meaningful and lasting changes in their lives. We have continued our journey against great odds, and have pursued our dreams and goals.

ESDO implemented programs in 110 upazilas under 26 districts, reaching over 6.80 million poor and vulnerable people directly. We have not only stepped into new geographic areas, but have also formed new and stronger alliances and partnership with development agencies from home and abroad – all with the singular aim of serving more disadvantaged and marginal people and adorning their lives with self-belief, hopes and inspirations. We have been assisted in our efforts by the ESDO family members – whose dedication and dynamism, care and commitment have always proved vital for our success. The sincere cooperation and unstinted support of our development partners and beneficiaries also have played a pivotal role in achieving our goals.

In this age of globalization, people have been facing many new challenges concerning their livelihood and their quest towards development. ESDO feels that, those who are termed as 'vulnerable' and 'marginalized', hold great potential to change their fate if they can join their hands together and receive necessary assistance from government agencies, national and international development organizations, public representatives and the larger-cross sections of people. Our endeavors and achievements in the last 23 years in the fields of social development, food security and disaster management, agricultural development, rights and governance, education, health, nutrition, environment and microfinance and entrepreneurship development have transformed the lives of hundreds of thousands of people in building their capacity and attain self-confidence, leading to self-reliance. We are immensely proud of this achievement and vow to continue our humble efforts to bring smile to the face of many more disadvantaged people in the coming days.

II. Hard To Reach Community On Maternal And Neonatal Mortality Reduction: The Understanding Of Esdo

There is a lack of clarity about what exactly is meant by 'hard to reach'. The term is employed inconsistently; sometimes it is used to refer to minority groups, such as ethnic people, or disadvantaged people; [1] it can be used to refer to 'hidden populations', i.e. groups of people who do not wish to be found or contacted, while at other times it may refer to broader segments of the population, such as old or young people or people with disabilities [2]. In the service context, hard to reach often refers to the 'underserved', namely minority groups, those slipping through the net, and the service resistant [3]. An alternative term used in the sampling

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context is 'hidden populations' [4] [5], as in they are hidden from the point of view of sampling.

This is borne out in medical and health research where hard to reach often appears in relation to the ability of health services to reach out to certain difficult to contact (or difficult to influence using existing techniques) segments of the population [6] [7] [8]. Here hard to reach are also equated with the 'underserved', which can mean that

Either there are no services available for these groups or, more often that they fail to access the services that are available [9] [10]. The reasons why hard to reach people are of such concern in the medical and educational fields is that they tend to have poorer health and Educational outcomes, which is why reaching them is of particular concern to those working with young people and in youth services [11].

Considering the above circumstances, ESDO has defined hard to reach area for implementing Maternal and Neonatal Mortality Reduction program on the following way:

a) Geographical dislocated segment
b) Socio cultural excluded segment
c) Un serve and underserved segments

ESDO's health, nutrition and sanitation programs have played a significant role in fulfilling the health needs of the vulnerable people in a wide geographic area. ESDO provided various types of reproductive, child and general health services by operating a satellite and static clinics through development of Community Support Groups for Maternal and Neonatal Care and Services. ESDO's ongoing and recently completed projects on health, nutrition, water supply and sanitation have helped approximately 05 million people reduce their health risks and enjoy a better health and sanitation status, directly impacting their livelihoods. To ensure unhindered growth and development of the new born and infants, ESDO carried out a comprehensive growth monitoring and promotional activity through regular follow-up, supervision and monitoring. This has contributed in combating malnutrition and raising hopes for a better and healthier future for our new generations [12].

According to the consideration of hard to reach area ESDO's ongoing maternal and neonatal mortality reduction program information has given below:

a) Geographical dislocated segment

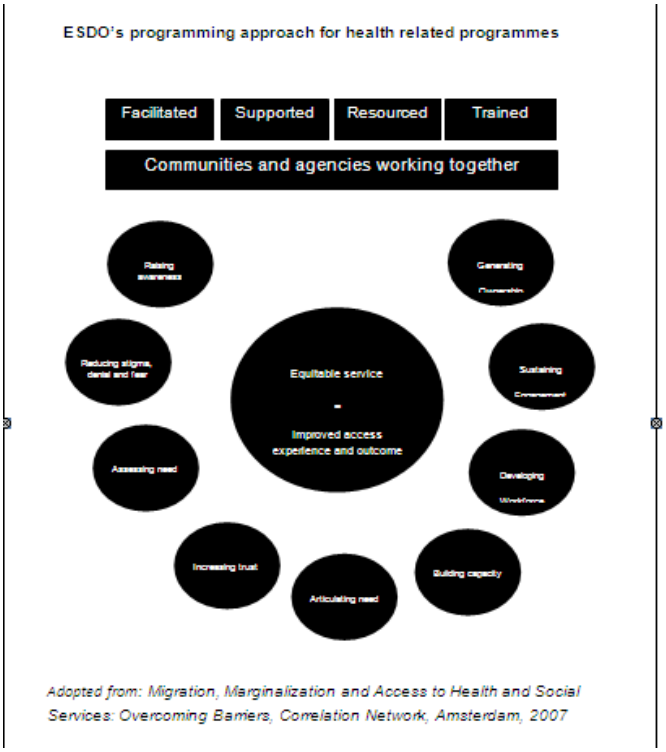
Sl. No.	Name of Projects	Working Area (District)	No. of Participants	Donor/ Development Partners
1.	Strengthening Household Ability to Respond to Development Opportunity (SHOUHARDO II)	Sirajgonj	27595	CARE-Bangladesh/ US-AID
2.	Chars Livelihoods Program (CLP)	Jamalpur	430	DFID-Maxwell Stamp/PLC
3.	Improving Maternal and Child Nutrition (IMCN) Component Under the Country Programme (CP)-2011-2016	Gaibandha	55300	World Food Programme (WFP)
4	Community Managed Quality Health Services (CMQHS)	Lalmonirhat	89486	Plan-Bangladesh
5.	Community Managed Health Care	Lalmonirhat	Open	Plan-Bangladesh
6.	Sustainable Micro Sanitation Project (SMSP)	Nawabgonj	10872	Max Foundation-Netherland
	Total		**183683**	

b) Socio cultural excluded segment

Sl. No.	Name of Projects	Working Area (District)	No. of Participants	Donor/ Development Partners
1.	Development of Community Support Groups for Maternal and Neonatal Care and Services through Community Development Interventions (ComSS)	Thakurgaon	257816	UNICEF /UNFPA/WHO/EU-DFID/GOB
2	Promotion of Rights for Adivashi and DALITS Improvement Programme (PRADIP)	Thakurgaon and Dinajpur	999	HEKS-Zurich
	Total		**258815**	

c) Un serve and underserved segments

Sl. No.	Name of Projects	Working Area (District)	No. of Participants	Donor/ Development Partners
1.	Development of Community Support Groups for Maternal and Neonatal Care and Services through Community Development Interventions (ComSS)	Thakurgaon	257816	UNICEF /UNFPA/WHO/EU-DFID/GOB
2.	Sanitation, Hygiene & Water Supply Project (SHEWA-B)	Panchagarh	118780	GOB-UNICEF
3.	Improving Maternal and Child Nutrition (IMCN) Component Under the Country Programme (CP)-2011-2016	Gaibandha	55300	World Food Programme (WFP)
4	Community Managed Quality Health Services (CMQHS)	Lalmonirhat	89486	Plan-Bangladesh
5.	Community Managed Health Care	Lalmonirhat	Open	Plan-Bangladesh
6.	Sustainable Micro Sanitation Project (SMSP)	Nawabgonj	10872	Max Foundation-Netherland
7.	ESDO Community Hospital	Thakurgaon	Open	Own
Total			532254	



[13]

III. Situation Analysis: The Common Scenario Of Health Feature In Hard To Reach Area

"The world is full of suffering: it is also full of overcoming it."- Helen Keller

Health services are not common in hard to reach areas. Lack of health services are found in hard to reach area. The common scenario of health facilities in hard to reach areas are as follows:

- Distance, geographical barriers and long travel times to health facilities remain key obstacle in hard to reach area.
- The cost of seeking care may delay or discourage hard to reach poor households from taking health behaviors.
- Un served and underserved areas also create a problem in delivering service in hard to reach areas.
- Socio cultural barriers hinder for providing gender related health services especially excluded segment of the society.
- Lack of proper knowledge, sensitization and awareness.

IV. Exclusion To Mainstream: The Interventions And Success In Esdo Health Program

- Growth Monitoring Promotion for 0-2 year's children.
- Provide nutrition ration package for pregnant and lactating mothers.
- Ensuring immunization for all children.
- Courtyard session and counseling for mothers.
- Provide health related service on maternal health, reproductive health, child health, adult health, family planning and nutrition to char community through satellite clinic.
- *Char Shastho Karmi* (CHK) provide support on ANC, PNC, family planning, ENC, prepare pregnant women list, under 5 children list, nutrition support, BCC activities etc.
- Provide nutrition education to pregnant and lactating mothers.
- Functioning Family Welfare Center (FWC) to reduce mother and child death.
- Material support for Community Clinic.
- Functioning Community Clinic groups.
- Formation of community support groups.
- Referral system
- Awareness raising about five danger signs, birth planning practices, immunization, thermal care to the newborn, three delays, ANC check up etc.
- Ensuring safe delivery at community clinic. Pregnant mothers especially poor, extreme poor and excluded segment of the society are more interested to deliver their child at community clinics rather than traditional practices.
- Supplementary food distribution among the pregnant and lactating mothers.
- Free treatment through medical camp for excluded people.
- Establishing community pharmacy for ensuring 24 hours medicine facility.

V. Challenges

Geographical dislocation creates unfavorable communication systems especially in Char areas.

- Shortage of Govt. staffs in FWC/ CC.
- Lack of awareness regarding the rights to get service from the service provider as well as responsibilities to provide services to the health service seeker.
- Lack of interest of technical staffs (doctors, paramedics, nurses etc) to work in hard to reach area.
- Inadequate functioning of Family Welfare Centers.
- Emergency Obstetric Care (EOC) unit is not functioning well.
- Temporary Migration of Mother (for earning during family crisis)
- Natural disasters hit frequently in the geographical disadvantaged area
- Excluded people are more fatalists to receive modern health services.

VI. Measures To Be Taken To Address These Challenges

- High dedicated staffs are engaged in Char area.
- Common understanding has been setting up for both service providers and health service seekers.
- Provide parallel support for strengthening FWC, EOC.
- Prepare contingency plan.
- Social campaign and awareness will breakthrough excluded people's mind setup.

VII. Lesson Learnt

- Community support groups work as a vigilant for ensuring community level health in the community.

- Community Health Volunteer (CHV) works as change agents for raising awareness on health related issues among the community especially in the hard to reach area.
- In hard to reach area nutrition ration will help to reduce malnourished situation.
- Awareness raising, counseling, motivation etc has been contributing in changing the mind setup of poor, extreme poor and excluded for safe delivery at community clinic.
- Male and family members has been changing their attitude towards pregnant and lactating mothers which has contributed in decreasing the death case of pregnant and children.
- Community pharmacy is a very good practice in hard to reach area for their 24/7 services.
- Establishing linkage with local leaders and the community acts as an important for ensuring access and sustainability and stimulating substantial changes for community behavior.
- Integration with others project (Micro credit, Social Development) has created enabling positive impacts towards maternal and neo natal health in hard to reach areas
- Effective Referral service successfully reduced child and mothers mortality.

VIII. Future Agenda

- Strengthening Government facilities in hard to reach area especially for poor, extreme poor and excluded people.
- Integration with different Government, Local Government and NGO for ensuring and enabling better health service in hard to reach area.
- Develop coordination, communication, commitment and combination among service seekers and service providers.

IX. Case Studies

Case study 1:

Adarsha *Gotamari* union is located in hard reach area of Hatibandha upazila where about 20797 population lives. The only health service facilities there was a two storied government health and Family Welfare Centre (FWC). The FWC was almost abandoned due to bad condition of the building scarcity of human resources, lack of equipments and supplies and run by one FWV. Regarding this issue community people has identified poor maternal and child health is one of the major problems in their community. With the financial support from Plan Bangladesh, ESDO has been implementing CMQHS project in Lalmonirhat district. Based on the community requirement, the provided has provided financial support to renovate the FWC and equipped the centre with facilities for safe delivery. To ensure maternal and child health services six days in a week additional human resource was provided. Now to ensure safe motherhood delivery service remains open 24 hours a day. Regular monitoring by the FWC management committee and maintaining the books of accounts ensure transparency and accountability to the community. The committee has opened bank account and mobilized fund from contribution of the community and union parishad. The fund is being utilized for repairing the boundary wall and providing salaries of support staff (*Aya* and cleaner) for ensuring the security and cleanliness of the community clinic. On an average 50-60 mothers and children receive health services from the FWC per day. Each month average 18-25 deliveries are conducted.

Case study 2:

Shanu lived with her husband in Badhpara. She was pregnant on 25 July 2010. She did not know about the available MNHI facilities in her community. But after her pregnant, Ms. Merina Begum CHV of ComSS project register Shanu's name in Mother Group. Suggested by CHV Ms. Merina, Shanu regularly attended the Mother Group meeting. In these meetings, she learnt about MNH issues. She learnt about the danger signs during pregnancy, 4 checks up during pregnancy, institutional delivery, supplementary food required during pregnancy, iron & folic acid, birth planning, newborn care, delay bath, thermal care, breast feeding within one hour, referral place and its system, emergency contact number etc. Not only Shanu but also her family received information regarding MNH issues through BCC sessions in courtyard meetings. Shanu's expected delivery date was 2 July 2011. On 4 May 2011 at 2 PM, Shanu felt labor pain. Immediately, her husband communicated with the CHV Ms. Merina. Ms. Merina is a trained skilled birth attendant. When Shanu's husband contact with Merina, she suggested him to take Shanu at Mujabonni Community Clinic as early as possible. Shanu reached Mujabonni Community Clinic at 3 PM. Shanu has given a new born baby at 10 PM with the help of CHV Merina. Shanu and her family were happy seeing their new born baby without any service charge. Shanu expressed her deep gratitude to MNHI service providers as well as ComSS project.

X. Conclusion

In Bangladesh country context, Maternal and Neo Natal Health in Hard to Reach Areas still now a challenge. A positive development has already made in maternal and neo-natal health in general areas which have contributed a significant coverage but remaining hard to reach area is the major challenge. There is no specific model for addressing appropriately the issues, it should be demand driven, need based and effective integration with others program and finally with the proper leadership of Directorate of Health and collaboration with all relevant service providers can make effective sustainable way to Exclusion to Mainstream: Towards Maternal and Neo Natal Health in Hard to Reach Areas of Bangladesh. ESDO has illustrated some Best Practices and we are firmly believed that these best practices will contribute for next steps.

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