

KOLLYANI; a Community Led Health Care Program at Tribal Villages of Bandarban District

Bangladesh

A case study

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Disclaimer

The case study has been compiled after primary and secondary research on the organizations and published with their approval. The case has been compiled after field visits to the organization in September 2011. The author of the case or ACCESS Health International is not obliged or responsible for incorporating any changes that may have occurred in the organization thereafter. The case study has been developed with a specific focus to highlight some key practices/interventions of the organization and does not cover the organization in its entirety.

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Executive Summary

Bandarban is a district in South-Eastern Bangladesh, and a part of the Chittagong Division and Chittagong Hill Tracts. This case study was conducted in the last week of September 2011, on a health care model at the remote tribal areas of Bangladesh named “Kollyani” means doing good jobs. Bandarban is the most remote district in terms of its geographic pattern, given its vast forest, hills and peaks. To make access more difficult, the area has very limited roadways and other modern communications. The majority of population is from 13 tribal groups of different ethnicities. The language and customs are distinctive from the mainstream population of Bangladesh. Although the size of the population is less than 300,000 in this district, it seriously lacks in formal health facilities and healthcare providers. The religious leaders of the respective tribal groups, traditional healers or unqualified village doctors are the usual service providers for the communities.

In 2008, Concern Universal Bangladesh (CUB), and three of the local NGOs, Gram Unna yon Sangathon (GRAUS), EKATA, YPSA as well as some active community members came forward to work toward improving the health situation of these tribal villages. With technical support from the international organization Concern Universal and the national organization GRAUS, the community led the process to establish a formal primary health care set-up at an accessible distance from the villages. Twenty such clinics were built in Bandarban and Cox’s Bazar district. One of the community leaders donated land to build a two-room clinic in each location. Others donated homegrown bamboo and bamboo products, trees, branches, ropes, sand and other material for raising the structure of the clinics. Those who could not donate anything offered their labor services to build the facilities. Some others provided food for the laborers as daily wages.

This case study is limited to GRAUS-CUB partnership for a total of six such community clinics at two upazila¹s of Bandarban. Each clinic covers a total population of 2000-3000. An executive committee from the villagers has been formed for running each of the clinics. The committee identifies native women willing to work for the clinics. Based on their level of education, each clinic is assigned two workers; one is the service provider/health worker

¹ The districts of Bangladesh are divided into sub districts called Upazila Parishad (UZP), or Thana. Upazilas are similar to the county subdivisions found in some Western countries. Bangladesh, at present, has 500 upazilas and 509 administrative thanas. The upazilas are the second lowest tier of regional administration in Bangladesh

and other one is the service promoter. In addition, several village volunteers are attached to each of the clinics working for health education and health promotion.

It is very difficult to get health workers with the required level of education to work in these remote villages. Women selected from the native community received three months intensive training on primary health care including ANC, PNC, and the treatment of diarrhea, the common cold, cough and other minor ailments. The training and technical support is provided by Concern Universal Bangladesh and the local NGO GRAUS. The government also extends its support to these clinics in providing family planning, anti malaria drugs and malaria testing. As a mandate toward achieving MDG 4 (improve Child health) and MDG 5 (improve maternal health) the government health workers come to these clinics every month for an immunization session. The government supplies family planning pills, condoms and other drugs and commodities to those clinics for primary health care.

The communities are getting results from these “Kollyani” clinics. There is significant reduction of under-five children mortality and maternal mortality. The villagers are now aware of pregnancy complications and referral system. In the absence of road communication the villagers carry the pregnant women thereby acting as a “human ambulance” or palanquin. The number of malaria cases has come down sharply due to availability of tests and drugs in the Kollyani clinics. The higher-level government health officials acknowledge the facilities in the absence of public ones. The occasional visits by government officials to these clinics have improved the morale of the community people and the providers. Additionally, each of the clinics has its own revolving drug funds that mobilize its resources while collecting a minimum user fee. The community has its own business plan for income generation for the clinic in order to make this initiative sustainable. It thus has local investment on agriculture, e.g. nursery, and poultry or teak plantation. In the case of a health emergency such as maternal health care the executive committee allows use of these funds. The executive committee meets regularly to ensure successful operation of the clinic.

The community-led Kollyani clinic and the health care program have been contributing to national health by providing primary health care in the remote villages and to those who are marginalized. The local people are content with the services they receive especially for their children and pregnant women. While meeting with community leaders they expressed satisfaction for the technical support of Concern Universal and its local partner GRAUS. On the other hand, the communities are aware of sustainability issue of the clinics. The community capacity needs to be further strengthened. They need more technical and financial assistance. Government and donors need to be come forward.

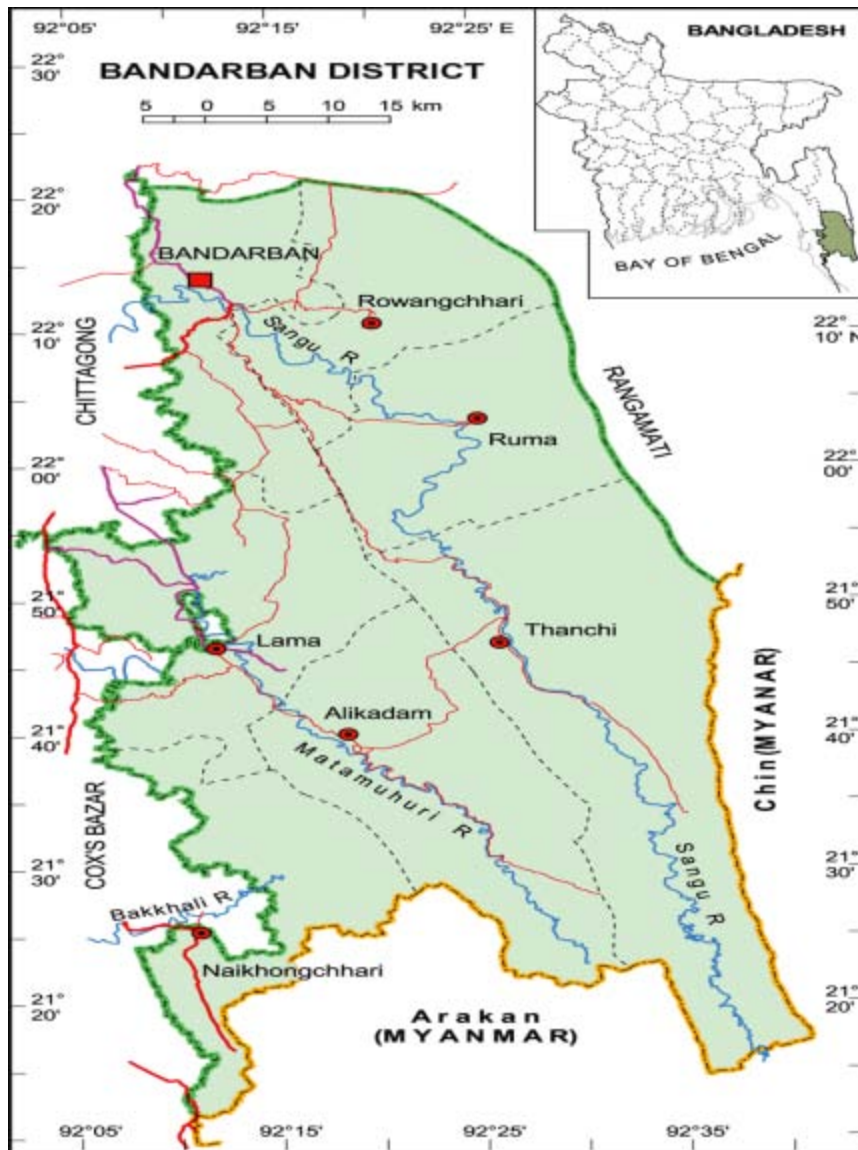
Introduction

Bandarban is one of the three hill districts of Bangladesh and a part of the Chittagong Hill Tracts. It (4,479 km²) is not only the remotest district of the country, but also is the least populated (population 292,900). 48 percent of the total population of this district belongs to the ethnic minority. There are more than fifteen ethnic minorities living in the district besides the Bengalis, including the Bomong, Marma, Mru, Tanchangya, Khyang, Tripura, Lushei, Khumi, Chak, Kuki, Chakma, Rakhine or Arakanese, Riyang, Usui and Pankho. The religious composition of the population, as of 1991, is 47.62 percent Muslims, 38 percent Buddhists, 7.27 percent Christians, 3.52 percent Hindus and 3.59 percent others². The Marma, also known as Magh, of Arakanese descendants, are Buddhists by religion and are the second largest ethnic group in the hill districts of Bangladesh. The case study was conducted at two Marma villages.

Concern Universal Bangladesh (CUB) is contributing to the Millennium Development Goals (MDGs) and addressing the national target in response to the objectives of the Bangladesh Poverty Reduction Strategy (BPRS), works. CUB dedicates its technical and financial support to the vulnerable and under-served communities together with the government, local institutions, NGOs, national and international organizations to reduce maternal mortality, child mortality, infant mortality and improve the local health services. Bandarban district is one of CUB's intervention areas where tribal and marginalized populations live and where social and health service are almost absent. Gram Unnayan Sangathan (GRAUS) is the local counterpart of CUB that provides direct support to the Marma tribal communities at six remote villages in providing access to health care services through primary health care clinics branded as "Kollyani."

This case study has studied the service delivery model of Kollyani, the inputs invested and the outcomes produced in terms of health and social development and the issue of sustainability.

² http://amardesh.com/zilla_bandarban.php



Concern Universal Bangladesh

Concern Universal Bangladesh (CUB) is a UK based international NGO that has been working in Bangladesh since 1993. The organization is especially dedicated to endorse people's rights and to uphold their dignity. It reaches out to the poor, marginalized and deprived people to provide them with basic social services like health, education, water and sanitation etc. The health program of CUB is thus being implemented in the most remote district of Bangladesh, Bandarban, where people are isolated from the modern world and access to health care is seriously lacking. The health care initiative of CUB focuses on primary health care with viable referral linkages to secondary and tertiary care centers. However, maternal and child health care is the core component of intervention, which contributes to national program of achieving MDG 4 (reducing child mortality) and MDG 5 (reducing maternal mortality). CUB follows certain key strategies for implementing health interventions. They are:

- Value partnership and uphold everyone's contribution.
- Focus on the community; located at the center of a public place for easy accessibility, local planning, respectful to communities' norms and traditions
- Community empowerment through capacity enhancement and resource mobilization.
- Best use of community/local resources including human and materials.
- Integrated approach with other related projects e.g. education or agriculture.
- Ensure accessibility, affordability and equity.
- Ensure quality of care.
- Sustainability.

The current health program of CUB extends its support to Bandarban and Cox's Bazar district through partnership with a local NGO named GRAUS and EKATA at Bandarban and YPSA at Cox's Bazar. It has been supporting a total of 20 primary health care "Kollyani"³ clinics in two districts. The health program has the following core components:

- Primary health care service delivery according to the government's essential service delivery package, e.g. Antenatal care, postnatal care, reproductive health, family planning, EPI, childhood illness like diarrhea, acute respiratory infection, common

³ Kollyani is Bengali word meaning doing good jobs.

cold and other minor ailments. Besides this, diagnosis and treatment for malaria is one important component of service delivery since the areas are malaria prone areas.

- Revolving drug fund – CUB has provided seed money for the drug fund.
- Behavioral change communication - the program has continuous efforts to increase knowledge and awareness of community people for changing behavior for promoting health.
- Capacity building- the health intervention not only invests resource for building capacity of service providers but the community people and volunteers toward health.

The target groups and beneficiaries of CUB are shown in the following table:

Target groups	Beneficiaries
<ul style="list-style-type: none"> • Women (reproductive age group) • Neonate (New born babies) • Under five Children • Elderly people • Disabled people • General people 	<ul style="list-style-type: none"> • Total 37770 hard-to-reach community people in CHT • Male – 16445 • Female – 15274 • Under five children - 4224 • A total of 78,798 indirect beneficiaries in the hard-to-reach community in CHT.

This case study only focused on CUB-GRAUS partnership at two Upazila⁴ namely, Bandarban Sadar and Rowangchari of Bandarban district.

Gram Unnayan Sangathon (GRAUS)

GRAUS is a Bandarban based local NGO working since 1998 for local communities of different tribal groups namely: Marma, Chakma, Tanchangya, Bawm, Tripura, Mro, Khumi, and Khyang. Since its inception GRAUS has been working with different national and international organizations for the promotion of human rights of poor and disadvantaged people of Bandarban hill district. The organization focuses on health, environment, education, child rights, economic development, community empowerment and disaster management.

⁴ Upazila is the sub-district level administrative unit in Bangladesh.

GRAUS is formed and managed by tribal people and it is a local resource in terms of understanding the tribal communities' customs, social values and religious norms. The colloquial language of each of the tribes is different and most of the tribes have no second language other than its own. GRAUS is therefore bridging the language barriers too.

Concern Universal Bangladesh has partnered with GRAUS to implement health interventions with the local communities. Both the organizations have supported the community led primary health care clinic "Kollyani", an innovative health care system for the rural disadvantaged people of remote hill districts. GRAUS has also partnered with different UN and international organizations for health and social development intervention beyond this case study.



Bandarban Hill District

Almost fifty percent of the total population of Bandarban district is from fifteen ethno-lingual communities. These groups profess diverse faith. Each group has a unique culture, which is different from the mainstream culture and is at varied/different levels of development (economically and educationally). Most of them live in the hard-to-reach areas such as hilly terrains or the forest areas where access is generally difficult. Moreover, many of these tribal groups are also characterized by slow/low growth rate compared to mainstream people.⁵ Heavily dependent on Jumm farming, which is a slash and burn⁶ agricultural technique, Bandarban produces little that is of

economic value outside of self-consumption by the hill people. Fruits (banana, pineapple, jackfruit, and papaya), spices (ginger, turmeric) and tribal textile are the major source of income of the district.

⁵ www.mohfw.gov.bd

⁶ Slash-and-burn is an agricultural technique which involves cutting and burning of forests or woodlands to create fields.

The health-seeking behavior, perception of family planning and its practices is poor. The nutritional intake, social behaviors and aspirations vary from one tribal/ethnic community to another. The religious leaders, traditional healers and local quacks are the key health service providers. All the health indicators are below national average in the Chittagong hill districts and Bandarban is also a part of it. Maternal morbidity, mortality, infant mortality rate are higher than other plain districts. Malnutrition and anemia is common among women and children. Malaria is one of the killer diseases at Bandarban like other hill districts. Safe drinking water is a major problem. The sanitation system is absent, people do not use latrines and open-air defecation is common, which is the source of water borne diseases in these areas. Simultaneously, a formal health care system does not exist. The existing public health facilities continuously suffer from absenteeism of medical staff and lack of supplies and logistics.

KOLLYANI Clinic

Kollyani is the community led clinic supported by CUB and GRAUS. It is within accessible distance from the villages. It ensures accessibility, affordability and equity among the villages. The primary objectives of Kollyani are:

- Quality of care
- Efficiency
- Equity
- Capacity building
- Sustainability

Of the 20 Kollyani clinics that are supported by CUB and GRAUS, six clinics are located in remote villages of Bandarban.



Formation of Kollyani

In 2009, considering the socio-cultural and health situation of villages, Concern Universal Bangladesh and GRAUS joined hands with the local communities to establish primary health care clinics. Through a participatory approach this initiative identified the most remote locations to set up clinics. The communities appreciated the steps for its own sake and came forward. A Community Executive Committee (CEC) was formed at each of the



Kollyani locations. One community leader donated land for building the clinic. Others offered homegrown construction materials like bamboo, ropes, trees, shades, floor mats and others necessities. Those who failed to donate due to their poor financial condition came forward for physical labor. Women provided food to the laborers during the construction period. Finally, with the active participation from the communities, six Kollyani primary health care clinics were built. The architectural design of these clinics was in alignment with tribal people's housing and it was also cost efficient. Every clinic has eco-friendly water and sanitation provision with a tube-well and latrine. There is a provision to collect rainwater during the rainy season. The reservoir has been made with financial and technical support from the government and CUB.

The people usually live in dispersed fashion in hill districts. Thus, each of the clinics covers a high population of 3000. The household coverage data is shown table below:

Name of Upazila ⁷	Name of Union ⁸	Clinic Location/Name of the village	No. of Households	Total beneficiaries /population
Bandarban Sadar	Rajbilia	Thangjoma Para	385	1571
		Hapigya para	183	788
	Kuhalong	Chang-O-Para	297	1291

⁷ The districts of Bangladesh are divided into sub districts called Upazila Parishad (UZP), or Thana. Upazilas are similar to the county subdivisions found in some Western countries. Bangladesh, at present, has 500 upazilas and 509 administrative thanas. The upazilas are the second lowest tier of regional administration in Bangladesh.

⁸ Union- the lowest administrative unit in government structure

Rowangchari	Rowangchari	Aongjal Para	217	897
		Paingkhong Para	207	908
	Taracha	Betchara headman Para	580	2286

Service delivery from Kollyani

Each of the Kollyani clinics opens from 9:00 a.m. to 5:00 p.m. six days in a week. Each clinic has one community health worker and one service promoter as full-time staff. Additionally, sixteen community volunteers both male and female and a number of trained traditional birth attendants (TTBA) are associated with each of the Kollyani clinics. The community executive committee and GRAUS jointly recruited the staff considering their educational qualification, communication skills and learning capacity. Notably, it is very difficult to get women who have completed their secondary school in rural areas as community health workers because these areas lack educational institutes and it is difficult for villagers to go to town for education. Therefore not only is the institutional certificate taken into consideration but



community leaders



Service providers

also their practical skills in managing primary health clinics.

After recruitment in the year 2009 both the community health workers and service promoters have gone through extensive training on primary health care and essential service delivery for three months. The Community Health Workers (CHWs) focused on practical skills and knowledge on primary health care service delivery and the service promoters focused on health promotion and communication skills, behavioral changes and awareness raising. The training material and manuals are tailor-made for this particular Kollyani initiative but approved by the Ministry Of Health And Family Welfare (MOH&FW). The local MOH&FW officials are the resource persons for the training course and the CUB and, GRAUS have continuous liaison and coordination with government officials. The

MOF&FW officials acknowledge these efforts in light of shortage of public facilities. Further, each staff member receives hands-on refresher training on different health topics on a quarterly basis. CUB receives funding and technical support for that.

Types of services available from Kollyani clinics are:

- Antenatal, Postnatal check up & safe normal delivery (assisting in home delivery).
- Assisting MOH&FW in Immunization services. The MOH&FW has a fixed immunization schedule for each village. The Kollyani staff and government vaccinator jointly operate the EPI session as per a fixed schedule. The Kollyani CHW, service promoter and volunteers facilitate the process of gathering mothers and children for receiving vaccines. Kollyani team also helps in follow-up and to reduce the incidence of dropouts. The EPI session cannot be carried out with help from the local health workers.



- Family planning – the CHW provides counseling services, family planning pills and condoms. It also helps improve awareness on long-term methods of family planning.
- Awareness on reproductive health and reproductive rights including HIV/AIDS.
- Treatment and education on diarrheal diseases.
- Preventive malaria services.
- First aid.
- Treatment of very common diseases.
- Satellite session - Each Kollyani team organizes satellite sessions in the remotest areas on a weekly basis to ensure accessibility and availability of services for the women and children.

The session usually coordinates with MOH&FW EPI/FP session to complement and supplement each other.

- Referral system - The executive committee extends its support for referral cases especially in maternal care by providing transportation cost and cost of emergency drugs. In the absence of a formal transportation system in these villages it uses “human ambulance” or palanquin⁹ to carry patients from the hilly or forest areas to better facilities.

⁹ A covered seat carried on poles held parallel to the ground on the shoulders of two or four people.

Meanwhile, this three-year (2009-2011) community led primary health care project conducted an independent midterm review in September 2010. Following are the notable successes recognized from midterm review of Kollyani¹⁰:



- More than 65 percent pregnant women received at least one ANC, which is close to the set project target indicator (70 percent).
- Women are aware of postnatal care. 60 percent of women received at least one PNC, 26 percent women received more than one PNC, which is again close to the project target.
- Maternal morbidity and mortality have reduced significantly with an increase in referrals to higher centers.
- The TTBA and medically competent persons are conducting more than 44 percent of deliveries, which is optimal according to the set target.
- Neonatal mortality rate is still an area of big concern, although under-five mortality has reduced significantly.
- Immunization coverage improved significantly and contributed to the national target of achieving EPI coverage. The full immunization coverage rate among the boys and girls are 86.8 percent and 85 percent respectively.
- Family planning awareness increased and more couples are accepting family planning methods as compared to before. Contraceptive Acceptance Rate (CAR) has increased from 36.2 percent to 59.9 percent in the study area.
- Social awareness regarding the early age of marriage, safe drinking water, sanitation and health has increased. This has resulted in a fewer number of early marriages before the age of 18 years, as well as a lower incidence of diarrhea and malaria cases with more referrals for better care.

Sustainability of Kollyani

The community executive committee is keen to sustain this initiative without external support from GRAUS or CUB. It has therefore introduced a user fee in the clinics. A flat user fee of only 05 taka (US \$ 0.07) is levied but there is safety net for the disabled and poorest

¹⁰ Summary of secondary data and documents were received from CUB and GRAUS

of the poor who cannot afford this. Besides this, Kollyani has a revolving drug fund. GRAUS and CUB facilitate the process of collecting drugs from manufacturers at a rate lower than the market price and provides the seed money to purchase drugs at the beginning of the project. The service providers sell the drugs to patients at a lower rate than the market rate and deposit the money into the drug fund. This clinic revolves these funds for the purchase of drugs and other daily consumable supplies (soaps, detergents etc.). In addition, the executive committee invests money for some income-generating activities for Kollyani e.g. cow/ goat rearing, plantation, textile weaving. The different community groups under the leadership of Kollyani executive committee like adolescent groups, mother groups and volunteers are actively involved in knowledge management process and making the initiative sustainable. There is regular monitoring by the executive committee to address the local problems for immediate local solutions rather than waiting for GRAUS or CUB. This is an example of community motivation to make this initiative sustainable.



Strengths of Kollyani

- Community participation and participatory approach is the uniqueness of the primary health care initiative at these remote villages. The World Health Organization reemphasizes the need for people-centered primary health, which is the foundation of health care system. The way Kollyani is built and its functioning is a unique example of community participation in health care. Community participation is crucial to sustaining such an initiative.
- Coordination with MOH&FW is an important element in the functioning of Kollyani. The EPI services, family planning and capacity building activities contribute to the national program for achieving MDG 4 and MDG 5 in coordination with MOH&FW local wings. The MOH&FW local wings have approved of Kollyani as an initiative that complements and supplements the government initiative. Joint satellite sessions for EPI and family planning enhance mutual relationship and show the importance of cohesion.

- Capacity building of community health workers, service promoters and different community groups adds value in improving community health, knowledge building and changing health-seeking behavior towards health. The capacity building initiative further adds supports to human resource for health.
- Combination with water and sanitation and other non-health local projects enhance accessibility to health care.
- Continuous monitoring from the executive committee and local NGO and feedback with a bottom-up approach facilitates achieving targets.

In conclusion, it is expected that replication and scaling up of community led health initiative would able to be get more national and international support to help the marginalized people for a better healthy life. All preventable deaths would be prevented and all children would able to enjoy their life as complete citizens.
