USAID -MUNICIPALITY - CONCERN WORLDWIDE BANGLADESH CHILD SURVIVAL PARTNERSHIP PROGRAM

FINAL EVALUATION REPORT

Saidpur and Parbatipur Municipalities, Rajshahi Division, Bangladesh

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- David Pyle and Dr. Jahangir Hossain
  Final Evaluation Team Leaders

ACRONYMS

ADB	Asian Development Bank
AI	Appreciative Inquiry
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
CA	Cooperating Agency
CB	Community-Based Organization
CC	City Corporation
CDD	Control of Diarrheal Disease
CHV	Community Health Volunteer
C-IMCI	Community Integrated Management of Childhood Illnesses
COLA	Cost of Living Allowance
CORE	Child Survival Collaborations and Resource Group
CSHGP	Child Survival and Health Grants Program
CSP	Child Survival Program
CSTS	Child Survival Technical Support Project
DC	District Commissioner
DIP	Detailed Implementation Plan
EmOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
FPAB	Family Planning Association of Bangladesh
GAVI	Global Alliance for Vaccine and Immunization
HICAP	Health Institution Capacity Assessment Process
HMIS	Health Management Information System
IMCI	Integrated Management of Childhood Illnesses
IOCH	Immunization and Other Child Health
ISA	Institutional Strengthening Assessment
JSI	John Snow, Inc.
KPC	Knowledge, Practice and Coverage Survey
LAG	Least Advantaged Group
LAMB	Lutheran Aid to Medicine in Bangladesh
LQAS	Lot Quality Assurance Sampling
MCH	Maternal and Child Health
MCHC	Municipal Central Health Committee
MESPCC	Municipal Essential Services Package Coordination Committee
MHD	Municipal Health Department
MNC	Maternal and Newborn Care
MOHFW	Ministry of Health and Family Welfare
MOLGRD	Ministry of Local Government and Rural Development
MOU	Memorandum of Understanding
MTE	Mid-Term Evaluation
NGO	Non-Governmental Organization
NID	National Immunization Day

NSDP	NGO Service Delivery Program
OCA	Organizational Capacity Assessment
ODU	Organizational Development Unit
ORT	Oral Rehydration Therapy
PD	Positive Deviant
PLA	Participatory Learning for Action
PP	Private Practitioner
PVO	Private Voluntary Organization (US-based NGO)
QoC	Quality of Care
RM	Regional Manager
RMP	Rural Medical Practitioner
SBA	Skilled Birth Attendant
TBA	Traditional Birth Attendant
TOR	Terms of Reference
TTBA	Trained Traditional Birth Attendant
UFHP	Urban Family Health Partnership
USAID	United States Agency for International Development
WHC	Ward Health Committee

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EXECUTIVE SUMMARY

Program Description and Objectives

The USAID-Concern Worldwide-Municipality Partnership Child Survival Program (CSP) is a four-year project that followed a successful two-year Entry Grant. The goal of the project is to contribute to the reduction of maternal and child morbidity and mortality, while increasing child survival through the development of a sustainable Municipal Health Service in Saidpur and Parbatipur in northwest Bangladesh. The project seeks to strengthen the municipalities' capacity to deliver specific child survival activities of good quality, which can be sustained within existing Municipal and Ministry of Health and Family Welfare (MOHFW) resources. Through a capacity-building partnership on multiple levels, the CSP seeks to improve services in immunization, vitamin A, maternal and newborn care, Integrated Management of Childhood Illnesses (IMCI – especially acute respiratory infections, diarrhea and malnutrition) and community health promotion.

The major strategy of the CSP involves building capacities, both management and technical (on selected child survival activities), at several levels (among *communities*, *municipal authorities* and *municipal health staff*, including providers, supervisors and managers). Concern Worldwide Bangladesh utilized Appreciative Inquiry while working closely with the various stakeholders in the CSP, training, facilitating, supporting the formation of health committees and mobilizing the community and existing human and financial resources on behalf of maternal and child health.

The five program outputs:

_ A developed Municipality health planning and management system
_ Institutionalized and well-managed activities (related to the interventions areas)
_ A sustainable community health promotion system
_ Competent and independent municipality staff and supervisors
_ Improved CSP planning and management

The CSP has identified and incorporated existing local community members into the health program. These include the Chairmen at the municipal level and Commissioners of the Ward Health Committee plus the private practitioners, teachers, traditional birth attendants (TBAs). The only cadre added by the CSP is the Community Health Volunteers (CHVs), students who work with approximately 50 neighboring households to educate and motivate them on improved maternal and child health practices.

Main Accomplishments

One of the major recommendations of the Midterm Evaluation was to expand the CSP interventions beyond immunization and vitamin A to include more emphasis on community-IMCI (C-IMCI) and improved maternal and newborn care. With the support of municipal authorities, the project has succeeded in its objectives of building capacities, developing and making effective health committees at both the municipal and community levels, and achieving impressive outcomes in terms of better knowledge and practices. In almost every case, the CSP surpassed the original targets. Among the major CSP **child and maternal health results** are:

Intervention	Saidpur			Parbatipur		
	1999	2004	Target	1999	2004	Target
Immunization	45%	71%	60%	49%	83%	65%
Vitamin A	63%	76%	85%	50%	80%	85%
ANC – at least 1 visit	58%	89%	70%	61%	87%	70%
- 3 or more visits	n/a	63%	n/a	n/a	70%	n/a
Delivery @ facility/hospital	25%	48%	n/a	24%	39%	n/a
Use of modern methods of contraception (mothers of <2s)	38%	55%	n/a	42%	65%	n/a

The contraceptive usage was not an explicit CSP objective but was integrated when it was identified as being essential if women's heath status were to be improved.

The CSP also improve the **behaviors** associated with C-IMCI. For example, immediate breastfeeding increased from 18% in Saidpur and 34% in Parbatipur to 47% and 75%, respectively. In addition, continuous feeding (food and liquids) during diarrhea also improved, from 18% to 63% in Saidpur and 25% to 64% in Parbatipur.

The CSP **capacity-building** activities strengthened not only the technical capabilities and performance, but also the ability of both the municipalities and communities to direct, coordinate and manage health operations. Both these bodies have been mandated by the Ministry of Local Government and Rural Development (MOLGRD) almost a decade ago but either do not exist or are only minimally functional (usually during the two annual National Immunization Days – NIDs). Use of Appreciative Inquiry techniques, skills training in planning, program implementation, data collection and analysis, problem identification and solution and consensus building resulted in the mobilization of the population and greatly increased visibility of maternal and child health issues. Utilizing special methodologies to monitor organizational capacities, Concern Worldwide and their partners were able to demonstrate significant improvements in the ability of the health committees at the municipal and community/ward levels to implement and manage health programs. The scores in the six municipal-level capacity area (leadership, coordination, participation, resource mobilization, human resource development, monitoring and evaluation) municipality rose in Saidpur from a 1.3 score in 1999 to 3.5 in most recent assessment; in Parbatipur it went from the same 1.3 to 4.5. At the ward level, capacity assessments also improved, on a slightly different scale, from 67 to 76 in Saidpur and 63 to the same 76 in Parbatipur.

Prospects for Sustainability

Having developed technical capabilities at the municipal and ward levels and having taken advantage of existing local health resources, the CSP has laid a strong foundation for sustaining the interventions and the tripartite partnership that has the shared goal of improving health status through their own efforts. They have raised funding to improve health services and support the poorest members of the community. By utilizing only existing persons who work on an entirely volunteer basis, no increased recurrent costs have been left behind to burden the cash-strapped municipalities. The turn-over rate among the CHVs is approximately 8%/year and has not been a problem because a system

of "apprentice CHVs" exists, meaning that a young person is typically available when a CHV is unable to continue. The TTBAs have proven to be most valuable in counseling and referring pregnant women to a delivery facility. The mobilized communities and the negotiated and signed Memoranda of Understanding that spell out respective roles and responsibilities of MESPCC membership assure that the CSP model can and will be sustained.

Priority Recommendations

The key recommendations are divided into retrospective and prospective categories. The first group includes ways to improve the CSP program as implemented in Saidpur and Parbatipur:

_ **Technical** - Continue to develop the Quality of Care/Quality Improvement aspect, introduce birth preparedness cards, include the homeopaths, further develop clinical/social verbal autopsies, and introduce a referral tracking system. In addition, CSP should continue to refine ARI/pneumonia, diarrhea, nutrition and maternal/newborn care interventions.

_ **Capacity-Building** - Improve the annual planning process by developing guidelines and consolidate the capacity-building monitoring tools into one that would be used to determine capacity at ward as well as municipal levels.

_ **Poorest** – Launch special effort to ensure total coverage/inclusion of poorest of poor.

_ **Advocacy** – Do more to document and disseminate results (health indicators and capacity building) so that other donors and public sector can incorporate and expand the approach.

The prospective recommendations refer to the next phase in which Concern Worldwide Bangladesh will introduce the CSP model to seven municipalities with a population of approximately 800,000:

_ **Operations Manual** – Develop a notebook containing all guidelines and curricula/ materials to facilitate replication.

_ **Local Catalyst** – Identify a local NGO (in many cases, an NSDP affiliate) to work with CSP during program implementation so that it will be there when Concern Worldwide moves on; this local NGO will support and assist the municipal health operation when/if required.

_ **Cost Study** – As interest in the CSP model grows, a study of the costs involved to launch and sustain the approach should be conducted.

I. INTRODUCTION

The goal of USAID's Child Survival and Health Grants Program (CSHGP) is to support US-based PVOs and their local partners to carry out effective, quality child and maternal health programs. An important aspect of these grants is an evidence-based evaluation at their conclusion. Concern Worldwide US engaged an evaluation team to conduct the Final Evaluation of the four-year (October 2000 – September 2004) Saidpur and Parbatipur Municipalities' Child Survival Program located in northern Bangladesh. The evaluation was carried out between 19 July and 12 August 2004.

A. Terms of Reference

Working in close partnership with the two municipalities, the goal of Concern Worldwide US and Bangladesh and the CSP was to reduce maternal and child morbidity and mortality. According to the Terms of Reference (**Attachment I**), the final evaluation was to be a participatory exercise to assess the performance and technical effectiveness of the program and develop overarching lessons learned. Although the Evaluation Team consisted of a number of persons involved in the CSP, it was led by two impartial and objective external consultants who have considerable experience in Child Survival programming in Bangladesh and elsewhere.

The three **CSP Objectives** to be evaluated were:

♦ Improve child health through immunization and environmental sanitation (to be measured by increases in % of 12-23 month children being fully vaccinated and receiving two doses of vitamin A); **targets**: immunization = 60% in Saidpur and 65% in Parbatipur; vitamin A = 85% in both municipalities;

♦ Improve safe motherhood and newborn care (increases in % of pregnant women attending at least three antenatal or ANC visits; % delivering at health facility); **target:** 70% of pregnant women receive at least one ANC visit; and

♦ Improve feeding and care-seeking practices for young children (increase % of mothers breastfeeding immediately after birth; % feeding their sick child properly).

Concern Worldwide Bangladesh did not deliver services themselves. Rather they devoted their time to building the capacities of the municipal health managers and health department as well as raising the awareness and mobilizing available resources at the community or ward[1] level.

[1] Wards are the smallest administrative urban units, ranging in population from several thousand in the smaller municipalities to over 10,000 in the larger municipalities.

B. Evaluation Team

Concern Worldwide US and Bangladesh formed an Evaluation Team that included 16 persons from various partners in the CSP, who participated on a full-time or part-time basis, led by two external consultants. The team was constructed purposively to be gender balanced and consisted of two representatives of JSI-Bangladesh (responsible for strengthening the Municipal health coordinating committees and providing technical assistance in Quality of Care) and a Human Resource Development Officer from LAMB Hospital. Several members from the respective Municipal Health Departments were included - one commissioner from each plus the EPI Supervisor from Saidpur and the Health Inspector from Parbatipur. There was also one person from Joyphurat (one of the new CSP expansion municipalities) who joined the team to increase awareness about the CSP approach and performance. There were four Concern Worldwide Bangladesh CSP staff (the Senior Project Manager, two Research Assistants, the Project Manager from each of the municipalities).

Dr. Jahangir Hossain, Team Leader and Safe Motherhood Adviser of the USAID-funded NGO Service Delivery Program (NSDP), was the national health expert and served as the Deputy Evaluation Team Leader, focusing attention on an in-depth review of the technical capacity building among the health staff and Quality of Care aspects of the program. Dr. David F. Pyle, Senior Associate of JSI based in Washington, DC, was the Team Leader of the Evaluation Team. The Child Survival and Health Advisor from Concern Worldwide US, Michelle Kouletio, joined the team following the pre-evaluation stakeholders meeting and preparatory phase.

C. Methodology

The Final Evaluation of the CSP involved a number of different components. First, the Team Leader met with CSTS+ on several occasions prior to reaching Bangladesh to discuss the capacity-building and sustainability monitoring framework. The Evaluation Team reviewed a large volume of documents (**Attachment II** – List of References) and secondary data. The program has carried out a number of studies and surveys, including population Knowledge, Practice and Coverage (KPC) surveys in 1999 and 2004 with abbreviated versions in 2001 and 2003. In addition, special studies on maternal health and Traditional Birth Attendants (TBAs) were carried out in 2002 and a TBA skills assessment in 2003. Capacity assessments were conducted in the two municipalities in 2000, 2003 and repeated in 2004 as well as at the ward level in 2003 and 2004.

Pre-evaluation meetings to get stakeholder feedback and input were held at the national level (**Attachment III** – Agenda and List of Participants) as well as at the field site (**Attachment IV** – Agenda and Participants). The Evaluation Team was divided into two groups, one (led by Dr. Jahangir) focusing on the technical capacity-building and quality of care issues, while the other (led by Dr. Pyle) concentrated on the capacity-building efforts at the municipal and community levels. Key informant interviews and focus group interviews (**Attachment V** – List of Persons Interviewed) were the primary source of data collection to substantiate project results and identify lessons learned and needs for

strengthening as the strategy is expanded over the next five years. The Core Evaluation Team reviewed and analyzed the findings and agreed on the evaluation conclusions, recommendations and lessons learned. Local (**Attachment VI** – Agenda and Participants), regional (for municipalities that will be included in the next phase of the CSP; **Attachment VII** – Agenda and Participants) and national (**Attachment VIII** – Agenda and Participants) stakeholders participated in three separate meetings where evaluation findings and recommendations were shared and discussed.

D. Report

The Final Evaluation of the CSP consists of several chapters. The following chapter provides background information on Concern Worldwide, the project's evolution and an overview of the urban health scene in Bangladesh. Chapter Three is the major section of the report. It contains the results and findings of the evaluation and summarizes what the CSP has achieved in the past four years. The discussion is divided into three sections, representing the major areas of intervention: the municipalities' health services, the municipalities' health management capacity and the ward health mobilization and management capacities. Each of these sub-sections highlights *what* CSP attempted to achieve, *how* the project pursued their objective, the *results* that were achieved, the major *findings* of the final evaluation, and the prospects for *sustainability* of the results. R*ecommendations* based on and relating to the findings are interspersed throughout the chapter. The Evaluation Team examined factors for success, best practices and describes tools/methodologies that have been employed. The next chapter reviews various aspects relating to Concern Worldwide's management of the program at all levels, concentrating on the field but also relating to Dhaka, New York and Headquarters offices as appropriate. The final chapter contains the major conclusions of the evaluation and lessons learned that can be applied elsewhere as well as a consolidation of recommendations into a limited number of priority suggested actions that Concern Worldwide US and Bangladesh should consider as it launches the next phase of replicating the urban health capacity-building strategy in seven district municipalities of northern Bangladesh.

II. BACKGROUND

A. Concern Worldwide in Bangladesh

Concern Worldwide began operations in Bangladesh in 1972 by providing post-war relief to refugees. Over the last three decades, the organization has focused on working for the betterment of the poor and most vulnerable people of the country. Until the mid-1990s in the health sector, Concern Worldwide Bangladesh delivered a package of health, nutrition and family planning services. An evaluation done in 1995-6 found the agency's health program in Bangladesh as one of the most expensive health efforts worldwide in terms of cost incurred for providing health services per beneficiary. To improve cost-effectiveness and sustainability, Concern Worldwide Bangladesh adopted a new strategy, shifting from direct health care delivery in the slums to attempting to harness the potential of municipal authorities and existing resources in the community through capacity building and the development of partnerships. The CSP is a part of Concern Worldwide Bangladesh's new approach and was developed to improve the health status of the mothers and children in their selected project sites.

B. Child Survival Project

In October 1998, Concern Worldwide US was awarded a two-year Child Survival Entry Grant to develop the CSP in two urban locations, Mymensingh and Saidpur. A shift in municipality leadership in the former just as the program was being launched and the lack of cooperation by the new municipal cabinet made it necessary for Concern Worldwide Bangladesh to withdraw from Mymensingh and start partnership operations in Parbatipur. Memoranda of Understanding were signed by the respective municipalities outlining the roles and responsibilities of the partners.

After orientation of the CSP staff in capacity-building methodology and techniques, local partners were trained in the approach, including municipal staff and elected representatives, Ministry of Health and Family Welfare (MOHFW) staff at *upazilla* and district levels, civil servants as well as community leaders and traditional health practitioners (e.g., TBAs) and stakeholders at national and program levels. Together with the partners, considerable research was carried out which enabled all relevant and involved actors to learn about the extent and nature of existing health problems among mothers and children in their municipalities. Studies carried out during the Entry Grant period included ward profiles, stakeholder analysis, Knowledge, Practice and Coverage (KPC) surveys, Health Institution Capacity Assessment Process (HICAP), Participatory Learning for Action (PLA) studies and Expanded Program for Immunization (EPI) facility assessment. Slowly, after initial resistance, health began to appear on the municipalities' agenda for the first time. In 1999, the Saidpur Municipality Chairman and Commissioners participated in the local National Immunization Day (NID), visiting outreach centers where they motivated staff and partners. The CSP Detailed

Implementation Plan (DIP) was finalized and the CSP begun in 2000 and will be completed the end of September 2004.

A Midterm Evaluation, conducted in the last quarter of 2002, found that the CSP had made progress in its capacity-building efforts at the municipal and ward levels, had trained a variety of formal and informal health providers and increased immunization and vitamin A coverage rates. But more remained to be done. Five key recommendations related to increased attention to maternal and newborn care and Community - Integrated Management of Childhood Illnesses (C-IMCI); need for greater networking and coordination with range of health providers; more thought given to an exit strategy and a strengthened Health Management Information System (HMIS); inclusion of private practitioners in Quality of Care efforts; and greater male involvement. Concern Worldwide US and Bangladesh and its CSP partners have worked hard and effectively over the past two years to address these concerns and Final Evaluation has found that they have achieved some impressive results and made important contributions regarding how to improve health services, increase coverage and put into place strong municipal and ward committees, all of which appear to be sustainable.

Taifur Rahman's publication, "Partnership with Local Government – Experience in Working for Urban Health System Development" produced by Concern Worldwide Bangladesh in August 2003, provides an excellent documentation of organization's transition from service delivery to capacity building and the initiation of the budding model.

C. Urban Health Situation in Bangladesh

According to the 2001 census, approximately 26% (over 36 million people) of Bangladesh's population is urban. Urbanization is increasing at a very rapid rate, an estimated 4.6% par annum. Consequently, urban centers are expected to increase to 33% of the population by 2010. Almost half of the urban population resides in the 6 large city corporations (CCs) - Dhaka, Chittagong, Khulna, Rajshahi, Barisal, Sylhet. The other half, or close to 20 million people, live in approximately 280 municipalities[2].

Urban health services are the responsibility of the Ministry of Local Government and Rural Development (MOLGRD). According to the Municipal Administration Ordinance 1960, the *Pourshava* Ordinance of 1977 and the City Corporation Ordinance of 1983, Municipalities and CCs are supposed to provide preventive health and limited curative care. However, limited resources and manpower have prevented public health services to keep up with municipal health needs.

In the latter half of the 1990s, the USAID-funded Urban Family Health Partnership (UFHP) and the Asian Development Bank (ADB)-supported UPHCP (Urban Primary

[2] The number of municipalities varies according to whom you are talking. No one seems to know the exact number since it changes frequently. It is constantly increasing. There are financial benefits (not in the health sector) that are associated with being designated a municipality. The most accurate number at the time the evaluation was conducted appears to be 284 municipalities.

Health Care Project) focused on strengthening urban health services. The ADB effort concentrated its resources in reproductive health interventions in the CCs. The USAID project and a significant portion of urban health support has involved the private sector, including both NGOs and private providers.

As Concern Worldwide Bangladesh was developing their CSP, they discovered that several 1995 circulars from the MOLGRD provided the basis for the development of an effective health partnership at the municipal level that includes the municipal authorities, the municipal health services and the community. One circular directed municipalities to form Municipal Central Health Committees (MCHC) while the other specified that each municipal ward should have a Ward Health Committee (WHC). Concern Worldwide Bangladesh identified these two entities as the core of the CSP and developed a project that built the capacity of these two bodies to improve and sustain quality maternal and child health services.

It should be noted that the municipal health services are extremely limited in terms of resources (both financial and human), control over services and linkages to the MOHFW. Over the last several decades, USAID has supported over 40 national NGOs to provide family planning services and more recently (in the NGO Service Delivery Program or NSDP) a package of basic Maternal and Child Health (MCH) services in 85 municipalities in Bangladesh.

IV. RESULTS AND FINDINGS

The results achieved by the Concern Worldwide US and Bangladesh and its partners in the CSP are impressive, both in terms of capacities in the local oversight bodies, at the municipal and ward levels, as well as in coverage rates in such important health activities as immunization, antenatal care (ANC), health facility delivery and utilization of modern methods of contraception. Concern Worldwide Bangladesh has monitored and can provide data to demonstrate improved capacities in the health services as well as at the municipal and ward program management levels.

This chapter is divided into three sections that analyze the results and findings of the three major activities of the CSP – building the technical capacities of the health services, building the coordination and management capacities of the municipal authorities and building the capacities of the wards to support and sustain a community-based health program. Each of the three sub-sections will address what CSP wanted to accomplish in that aspect, how it went about achieving their objective, the results attained by their efforts and findings analyzing the strengths and weaknesses of their operation and issues relating to how what has been achieved will be sustained; recommendations are interspersed as appropriate. Important cross-cutting issues (e.g., community mobilization, behavior change communication, strengthening local partner organizations, capacity building, health facility and worker strengthening, training) were integral to everything that Concern Worldwide Bangladesh and the CSP did and will be included in the discussion of each section.

A. Capacity Building – Technical/Health Services

To achieve its objective of improved protection of child health, young child feeding and care seeking practices and safe motherhood, Concern Worldwide Bangladesh identified a need to strengthen the capacity of the service-providing facilities and workers. Through a series of trainings, CSP upgraded the skills of the municipal health workers in management of EPI, basic health messages and behavior change communications (see **Attachment IX** – review of CSP training). These inputs were supported by improved supervision and monitoring.

1) <u>Results</u>: Project results demonstrated significant improvement in key indicators. Concern Worldwide US and Bangladesh and the CSP staff took the recommendation of the Midterm Evaluation (MTE) seriously and invested considerable energies in improving the services and knowledge/practices relating to maternal and child health and C-IMCI. The findings of the KPC conducted before the launching of project interventions were compared to the results of the KPC completed just prior to the Final Evaluation (**Attachment X** – KPC 2004 Report) showed that the CSP more than met almost all its objectives and targets stated in its project proposal. The Final Evaluation Team decided to focus on some of the most important outcome indicators.

Table 1
Major CSP Child and Maternal Health Results

Indicators	Saidpur			Parbatipur		
	1999	2004	% change	1999	2004	% change
Full vaccination coverage	45%	71%	+58%	49%	83%	+69%
Vitamin A coverage (12-23 mo)	63%	76%	+21%	50%	80%	+60%
ANC - at least 1 visit	58%	89%	+53%	61%	87%	+43%
- 3 or more visits	N/A	63%	-----	N/A	70%	-----
Delivery @ facility/hospital	25%	48%	+92%	24%	39%	+39%
Immediate breastfeeding (1st hr)	18%	47%	+161%	34%	75%	+121%
Food/liquids during diarrhea	18%	63%	+250%	25%	64%	+156%
Use of modern methods of contraception (mothers of <2s)	38%	55%	+45%	42%	65%	+55%

Each indicator has a story attached to it.

♦ ***EPI/Vitamin A (14% Level of Effort in Year 3 and 4)*** – According to the DIP, in support of the immunization and vitamin A activities, the CSP will:
_ improve quality of immunization and vitamin A services at outreach and fixed centers;
_ increase demand and participation in availing immunization and vitamin A services;
_ improve both management and technical skills of immunization and vitamin A distribution service providers; and
_ establish functional coordination between municipality and other relevant stakeholders both in government and NGOs for sustained cooperation in immunization and vitamin A service programming.

The increases in **immunization** coverage surpassed the target that was sited in Concern Worldwide US's CSP proposal of 60% in Saidpur and 65% in Parbatipur. These impressive results were partially achieved as a result of *training* the Municipal Health Department (MHD) staff in Saidpur and Parbatipur. The three-day course included such subjects as registration and target fixing, sterilization, cold chain maintenance, vaccine administration, counseling caretakers on side effects – all the components required for a successful immunization program. The MHD staff re-introduced use of a quality management checklist that was utilized monthly to monitor performance at both fixed and outreach centers. Other factors for surpassing the target include *child/household accountability* whereby resistant families are motivated and delinquent children are followed-up by WHC members and the CHVs and Trained TBAs (TTBAs) and recruited for vaccination. The *community is mobilized* and parents' *awareness raised* about the importance of and need for immunization. In addition, the CSP municipalities improved relations and established effective *linkages* with MOHFW and Immunization and Other Child Health (IOCH) programs.

Within one year, immunization program performance was tracked and increased dramatically and has stayed high over the last three years.

Table 2
EPI Performance

Indicator	2001	2002	2003	2004 (Jan-Jun)
Sterility/hygiene maintained	51%	90%	92%	100%
Cold chain maintained	63%	92%	99%	97%
Record keeping and reporting	77%	94%	97%	100%
Vaccine administration	77%	97%	99%	100%

Lesson Learned #1: *Supervision and accountability can be developed at community and municipality level to reinforce a local health system.*

Lesson Learned #2: *Even though immunization, and urban immunization in particular, has received more attention from donors and IOCH programs in the past, they still require some assistance. But the inputs required are minimal and performance can be improved with only a modest investment of time and resources. In contrast, Maternal and Newborn Care (MNC) and IMCI interventions are generally under-funded, hence requiring more emphasis and investment.*

Vitamin A (for ages 1 to 5) program management also improved – from 72% in 2001 to 100% in 2004. Coverage figures in the 2004 KPC survey findings (76% in Saidpur and 81% in Parbatipur) were not as high as one would expect because of a supply problem (lack of capsules from donor due to a shipment delay). This was the one key indicator that did not surpass the project target that was 85% for both municipalities. If vitamin A supplies are available, the CSP should be able to reach and even surpass the target the project established for itself prior to launch; this should be monitored to ensure as complete coverage as possible.

Recommendation #1: *The HMIS should include data on vitamin A distribution to under-five children and post-partum women (see below) so that problems can be identified when they occur and remedied.*

With the community mobilized and the MESPCC and the municipal health staff functioning effectively, one would expect very high, even universal, coverage rates. One hypothesis as to why not everyone is immunized involves the poorest members of the community, the so-called Least Advantaged Group (LAG). The final KPC looked at immunization and vitamin A coverage by socioeconomic group (by quintile). **Table 3** demonstrates that there is only a weak correlation between socioeconomic status and coverage rates.

Table 3
Immunization and Vitamin A Coverage by Socioeconomic Status

SES Quintiles	Full Vaccination (care and self report)	Vitamin A past 6 months child 12-23 months
Lowest	86.7	80.7
2	91.1	67.8
3	91.1	80.0
4	88.9	81.1
Highest	94.2	79.8
Average	**90.6**	**77.9**

Source: ACPR, July 2004

The CSP should look deeper into the reasons why a minority of the community is not getting their children immunized and receiving their semi-annual dose of vitamin A. The immunization coverage rates are high enough to protect the community and the children in it; it would not be cost-effective to attempt to achieve universal immunization since it would result in little or no improvement in the health status of the municipal population. However, universal vitamin A coverage is worth pursuing. It should be consumed by every child under five twice a year to improve their immunity and reduce mortality. Thus, the CSP should place emphasis on reaching universal vitamin A coverage.

Recommendation # 2: *The CSP should identify under-five children not consuming vitamin A capsules and interview their families to determine the reason for non-participation and devise a plan to achieve universal coverage.*

♦ ***Maternal and Newborn Care (30% Level of Effort)*** – One of the targets established in the original CSP proposal related to ANC coverage. Concern Worldwide US said that the Bangladesh CSP would achieve 70% of the pregnant women making at least one ANC visit during the course of their pregnancy. As Table 1 shows, this target was easily exceeded as the final KPC found that 89% in Saidpur and 87% in Parbatipur had one or more ANC visits during their last pregnancy. In fact, the KPC showed that more pregnant women were making three or more ANC visits than were making one visit when the baseline KPC was taken (63% vs 58% in Saidpur and 70% vs 61% in Parbatipur) four years earlier.

There were several explanations for the dramatic improvement in ANC coverage, including the training of the MHD staff along with the TTBAs, CHVs, Imams and members of the WHCs. Together, they raised the awareness of the importance of ANC, targeting and persuading pregnant women and their families. If a husband was reluctant to allow his wife to participate, he might receive a visit from the local Imam who would explain why ANC was vitally important, possibly citing references from the Holy Quran that encourage safe motherhood. Special efforts were made to involve and raise the awareness of males – e.g., some wards conducted "best father" contests in which a husband who supported his wife in safe motherhood practices would be recognized at one of the frequent national/international day celebrations (e.g., HIV/AIDS, Health) which are largely male gatherings. However, most often CSP participants mentioned the contribution made by the TTBAs who enjoyed the trust and confidence of the women and whose strong recommendation for ANC was hard to resist.

At the same time, there were impressive gains in the percentage of **deliveries conducted at health facilities**. The increase was greatest in Saidpur where the figure nearly doubled. Improvements in the quality of the maternity facility in Saidpur plus the cost of the private delivery facility (LAMB) in Parbatipur explains at least some of the difference. It was noted that the work of the MESPCC in Saidpur contributed to the achievement by being responsible for posting two medical doctors (both female) from the Saidpur Upazilla Hospital Complex outpatient facility to the 50-Bed Hospital in the municipality. Moreover, there was collaboration between the NSDP-supported Kanchan

Samittee clinic and the MCWC facility where the former referred patients wanting long-term/permanent methods of contraception.

In addition, the promotion of health facility deliveries by all the WHC members and partners increased the awareness of the importance of delivering in a health facility when the women experienced one of the five danger signs. A number of informants remarked on the quality and timeliness of the TTBAs' referrals. For example, LAMB said the diagnosis and judgement of the TTBAs' was consistently accurate. The TTBAs interviewed by the Evaluation Team were confident and proud of the work that they were doing; they now felt that they were a respected of the health system rather than outsiders. It should be noted that only a few of the TTBAs had received any training prior to CSP. They were not included in any of the numerous previous TBA training courses that had been carried out in Bangladesh over the last several decades. One said that she was interested to learn in her recent training that it was wrong to apply cow dung to the cord. In no case did a TTBA mention that there was any conflict of interest or question about referring a "customer" to a hospital – there was no sense of competition. If there was a problem or a potential problem, the health of the mother and infant came first. Some of the TTBAs had not delivered a baby in months, but they understood and appreciated what their new role was and did not complain.

The TBAs had been trained by LAMB in life-saving strategies and skills, including essential and emergency obstetric care. It includes three levels of care. The first is the community volunteer (i.e., the TTBA) who have no formal training but motivate on ANC and immunization, teaches danger signs of pregnancy, provides clean home delivery, recognizes complications and refers and carries out post partum visits and essential newborn care. The second is the local skilled/trained birth attendant at an obstetric care facility as might be found at the upazilla level. Third would be the LAMB Hospital having 24-hour delivery service that can attend to obstetric complications and referrals from both the volunteer as well as the intermediate level facility.

A study was conducted to determine how TTBA practices changed after the LAMB Hospital training they received. The results were positive as shown in **Table 4**.

Table 4
TTBA Practices after LAMB Training

Activity	Saidpur		Parbatipur	
	Baseline (Aug 03)	Follow-up	Baseline (Aug 03)	Follow-up
I. Antenatal				
Asked if any problem with pregnancy	25%	78%	17%	51%
Discussed birth preparedness – attendant	78%	93%	91%	100%
- place of delivery	71%	95%	86%	95%
- transport plan	20%	91%	85%	95%
- blood donor	0	81%	60%	98%
Advised on immediate breastfeeding	23%	82%	71%	88%
Discussed 5 danger signs during	31%	91%	29%	95%

Activity	Saidpur		Parbatipur	
	Baseline (Aug 03)	Follow-up	Baseline (Aug 03)	Follow-up
pregnancy & delivery				
Advised about family planning services	17%	95%	17%	91%
II. Postnatal				
With Mother – checked for fever	0	81%	50%	87%
- checked blood flow rate	0	76%	0	87%
- asked about discharge odor	50%	58%	0	87%
- asked about discharge color	0	61%	33%	78%
- discussed FP method choice	0	87%	50%	91%
- discussed where FP methods available	100%	87%	80%	98%
With Newborn – asked about urination frequency	50%	0	74%	87%
- asked about stool color	0	25%	77%	79%
- observes breastfeeding/advises	0	60%	77%	81%
- checked cord	0	90%	75%	94%
- advised when to go for EPI	100%	90%	100%	96%
- advised where to go for EPI	50%	81%	100%	98%

Source: LAMB, 2003 & 2004

These findings indicate that the TTBAs became very proficient in their interaction with both the prenatal and postnatal women. They are now able to ensure that the pregnant women are properly prepared for birth, especially if an emergency were to arise. They had to consider such important issues as finances, delivery location, how they'll reach the facility and who will donate blood if required. They seemed to be better prepared (i.e., higher baseline figures) in three of the birth preparedness issues (place of delivery, attendant, transportation) in Parbatipur, possibly because of the close proximity of and familiarity with the LAMB Hospital. There were impressive increases in the discussion of the five danger signs of pregnancy and delivery in both municipalities. The TTBAs also improved their postnatal and newborn care practices. The discussion of the importance of immediate breastfeeding helps explain the large increase in this indicator in the recent KPC. Several indicators relating to immunization and family planning were very high to start with primarily because of the efforts over the years by the government or other agencies in these areas. Moreover, it is likely that some of the TTBAs have been involved previously as volunteers in the NIDs.

In 2001, the national maternal health strategy for Bangladesh recognized the importance of having a skilled attendant present in all deliveries. Consequently, they began to provide midwifery training to front line Government health and family planning workers (e.g., Female Welfare Assistants and female Health Assistants). The course consisted of a 24-week basic obstetric care based on WHO's "pregnancy, childbirth and newborn care" curriculum. A total of 74 skills have been identified and checklists for skill practice were developed. The government is interested in expanding this program and donors

have expressed interest in supporting SBA training. The added responsibility[3] for already overloaded field workers concerns raises concerns whether they can effectively assume the role envisioned for them.

Recommendation #3: *Explore the integration of Skilled Birth Attendants (SBAs) efforts into the model since the MOHFW is recommending their promotion and use. At the same time, consideration should be given to what role the TTBAs can play in collaboration with the SBAs. The TTBAs are obviously an important partner in the ward-level health team, especially in their work with and support of the CHVs.*

The WHCs and community support in the form of funding also played a role in increasing facility deliveries. If a woman required hospitalization and could not afford the cost, especially at the private LAMB facility outside Parbatipur, the WHC could and did on a number of occasions negotiate with the institution to reduce the costs. This reduced amount would be paid for with a combination of family, WHC funds, and, in some cases, community donations. The women of the community now had confidence that if they needed medical assistance during pregnancy, cost was not an inhibiting factor.

The fact that two female doctors were now available at the 50-Bed Hospital in Saidpur also meant that the facility was now accessible and competent to address the needs of the pregnant women requiring assistance. And with both these physicians being female, the women of Saidpur were much more willing to patronize the facility. The quality of care intervention with the MESPCC was started later but was important in reinforcing the change that had taken place. In addition, respondents told the Evaluation Team that improvements in cleanliness of the facility and the client orientation and interpersonal communications by facility staff, all the result of CSP training interventions, made the women more eager to utilize them. It should be noted that Saidpur does not have access to 24-hour Emergency Obstetric Care (EmOC) since it is neither a district municipality headquarters, nor does it receive support from International Organizations such as UNICEF and UNFPA.

The Evaluation Team noted that **maternal health cards** were not being used and were not available in the project municipalities. The MOHFW has such cards and could supply them to the MHDs in Saidpur and Parbatipur. Similarly, **birth preparedness cards** were not in evidence to remind families of pregnant women what had to be thought of prior to the onset of labor (e.g., transportation, blood source, financial resources in case of emergency).

Recommendation #4: *The respective MESPCCs should make efforts to procure the maternal health cards, train appropriate workers to use them and begin monitoring care received by pregnant and postpartum women. At the same time, the CSP should advocate for the provision and universal use of birth preparedness cards.*

[3] According to calculations, it is estimated that if 13,000 midwifes/ SBA s were trained, each one would have to attend approximately 15 births per month.

The TTBAs also performed extremely well in the **postpartum care** aspect. Their impact on breastfeeding and contraceptive utilization will discussed below. Although no figures exist to support the claim, all the TTBAs interviewed by the Evaluation Team said they distributed vitamin A to the new mothers. More can be done to improve TBA newborn care, reemphasizing its importance and ensuring that it is done properly, especially relating to issues like hypothermia and the diagnosis and treatment of ARI/pneumonia. This can be linked with CSP activities in C-IMCI and with the Private Practitioners, especially (as will be discussed) the homeopaths. The most recent KPC found that among women who had delivered in the past year, a limited number received some of the important services within 48 hours of birth: postpartum and newborn checkup (39% in Saidpur and 54% in Parbatipur); newborns receiving two essential services (20% and 40%, respectively) and one essential service (31% and 45%).

While the **postpartum vitamin A** program functioned well when TTBAs were involved, it was not being implemented at the government maternity facilities due to lack of supplies. The matter was raised at the MESPCC meeting observed by the Evaluation Team and the MOHFW representative agreed to supply vitamin A stocks to the delivery facilities. This was a good example of how communications and collaboration between local partners can facilitate the identification and solution of problems in the health system.

CSP's achievements in **family planning** are interesting from several different perspectives**.** Contraceptive prevalence rates among mothers of children under two (modern methods only) increased significantly to 55% in Saidpur and 65% in Parbatipur. This was accomplished despite the fact that contraceptive utilization was not one of CSP's stated intervention areas. However, birth/child spacing was recognized as an integral part of improved maternal and newborn care and was a big part of the behavior change and communication strategy carried out by the TTBAs and the WHC team of volunteers. This enabled the CSP to take advantage of and build upon the work carried out over the years by the national Family Planning program.

Tracking birth intervals (i.e., % of mothers having children at least 3 years apart) was on the CSP agenda but not contraceptive prevalence *per se*. Considering the difficulty that some NGOs, whose primary objective is family planning, have in achieving similar results, CSP's achievement is remarkable. It is attributed to the high unmet need that was identified during the BCC study and the fact that the project decided that it should be included as part of the basic package of behaviors promoted by the partners. The CHVs began to note the households with recent births or with too many children and would request assistance in motivating that family to accept contraception. Because the CHVs are young and unmarried, they would frequently request the local TTBA to accompany her on one of her periodic visits to the house to discuss contraception.

_ ***Community-IMCI (C-IMCI) – Respiratory Infections, Diarrhea, Nutrition (20% Level of Effort) and Health Promotion (36% of Level of Effort) –*** The indicators and targets for the expected behaviors relating to the project's last three objectives and C-IMCI are listed in **Table 5**:

Table 5
CSP Behavior Change Indicators & Targets

Indicator	Target (%)
% of pregnant women using **ANC** three or more times	85
% of women with obstetric complications using **Emergency Obstetric Care**	50
% of mothers and other child caregivers using **Essential Newborn Care**	50
% of **pregnant women** receiving at least 2 does of **TT** vaccination	60
% of **women of reproductive age** received full **TT** vaccination	60
% of children with **ARI** treated by qualified doctors or health facility	50
% of 6-month olds given regular, appropriate **supplementary food** along with breast milk	50
% of under-fives with diarrhea given adequate **ORS** and regular diet	100

The CSP placed special attention on addressing **ARI/pneumonia** among the target population in the two municipalities since they are a leading cause of child mortality, particularly among young infants. The project has devoted considerable energy to raising awareness of the volunteers and WHCs regarding the danger signs associated with ARI/pneumonia. The fact that a high percentage of caretakers take their children to private practitioners, especially homeopaths, is a driving force behind the project's inclusion of the PPs and need to expand to include the latter category of providers.

In the prevention and control of **diarrhea**, CSP promoted ORT where needed as well as stimulated environmental health efforts. In Saidpur the use of ORT by under-fives having diarrhea within the last two weeks went from 48% in the baseline to almost 80% in the most recent KPC. In Parbatipur, the rate stayed virtually the same, in the almost 70% range. This is to be expected since the utilization rate was relatively high to begin with as a result of years of promotion by health providers, both government and NGOs, and through a variety of communication channels.

On the prevention side, the CSP has been able to make some progress in stimulating the communities to get involved in *environmental health and sanitation* efforts. Hand-washing promotion, emphasizing when and how it should be done, was included in the community orientation. Of particular note were community efforts. It was part of the awareness raising and some of the WHCs have initiated activities to improve the sanitation in their areas with street cleaning, waste removal, and drain cleaning and reconstruction. For example, one ward in Parbatipur charges every household Taka 10 (less than US$0.20)/month that is used to hire two sweepers that keep the streets clean. The municipality has agreed to send a truck every day to pick up the collected refuse. This is another case where the community and the municipality have collaborated with

the people benefiting. The Evaluation Team was told of several other wards having similar arrangements.

The CSP also included several **nutrition**-related activities in their C-IMCI component. For example, they promoted and featured *immediate breastfeeding* and continued feeding during diarrhea as a behavior change indicator and a reflection of CSP's C-IMCI effort. Both indicators had low baselines that made for impressive gains during CSP (see Table 1). In the case of breastfeeding, it more than doubled in both municipalities.

Equally positive results were achieved by the CSP in the *continuation of food and liquids* during a childhood episode of diarrhea. Although, as mentioned, the provision of ORS was reasonably good in both municipalities, feeding practices were low before the launch of the CSP. Promotion activities were successful and not only significantly increased awareness, but also changed behavior. Table 1 shows that it more than tripled in Saidpur and was up two and a half fold in Parbatipur. Now the question is, can this improved behavior be sustained?

Concern Worldwide Bangladesh has also introduced the *Positive Deviant/Hearth* approach and sent three staff members and partners to be trained in the methodology. The organization found this innovative technique effective in improving nutritional status of the target population and changing feeding practices in its Khulna project and will build upon the lessons learned.

Changes in health-related practices were attributed to reinforcement of the behavior change messages by many of the CSP ward-level health team. Concern Worldwide Bangladesh developed a credible BCC strategy that laid the basis for the effort. The WHCs received training and guided and coordinated activities in their respective areas. TTBAs seemed to be most responsible through her antenatal and postnatal counseling. In addition, the CHVs were highly active and were able to educate and reinforce messages and practices during their regular (often once or even twice a week) visits to the households. The school teachers, Imams and private practitioners all broadened and strengthened the BCC activities.

_ ***Private Practitioners (PPs)*** – Taking advantage of all health resources in a community is a noteworthy and innovative aspect of the CSP. Of particular importance are the Rural Medical Practitioners (RMPs) or Private Practitioners. Their importance is noted in an assessment carried out by CSP in mid-2003. All research and experience shows that two-thirds to three-quarters of those seeking health care in Bangladesh utilize sources other than public health facilities. A large portion of the target population utilizes providers who are unregulated, have little or no formal training and often provide poor care. They are rarely included in health projects. As a result, the RMPs/PPs remain outside the system, yet continue to serve the population with sub-standard health care. The most recent Bangladesh Demographic Health Survey (BDHS, 1999) found that for child fevers 29% of the caretakers went to private physicians, 23% to RMP/drug sellers and 24% to traditional practitioners/homeopaths. In comparison, hospitals, health centers and posts were visited by a total of 11% of the cases. This is similar to the findings from

ICDDR,B's long-established research site at Matlab where only 11% of the caretakers seek treatment for sick children at formal health centers while 53% go to village doctors, homeopaths and traditional healers.

According to the most recent KPC in the CSP catchment area, 41% of children under two having diarrhea in Saidpur and 40% in Parbatipur are taken to a traditional healer/ homeopath, pharmacy/drug seller or RMP. The figures are similar for ARI – 49% in Saidpur and 44% for Parbatipur. To address this issue and bring the RMPs/drug sellers into the health system as one of the partners, the CSP conducted "negotiation sessions" with a total of 85 RMPs/PPs, orienting them on danger signs for ARI and diarrhea cases and impressing on them the need for early diagnosis and referral. The RMPs/PPs signed commitments (see **Attachment XI**) with CSP agreeing to change certain behaviors and have worked closely together since. A group of eight "followers", chosen by the PPs/RMPs from among their ranks, monitor the work of the trained RMPs/PPs, using a simulation technique (i.e., pretending to have a sick child, describing symptoms to see if the RMP/PP follows established guidelines). The experience with these RMPs has been favorable – they have been interested in and active on behalf of improved child health. They are very pleased to receive the training that improves their image in the community that is good for business and helps make them become a respected part of the health system rather than an outcast. They benefit from the CSP in that they learn the danger signs for ARI and pneumonia that allows them to refer the sickest children so the chances of them dying and hurting their reputation is reduced or shifted to someone else.

One group that the CSP has not included in their training to date is the homeopaths who, according to the research, are most often contacted by parents in the case of infant ARI and diarrhea. The CSP is seriously considering recruiting and training homeopaths.

Recommendation #5: *The PP component should identify homeopaths in Saidpur and Parbatipur and work with them to develop an approach to include them in the CSP so that within the next year they are active, contributing members of the community health partnership.*

The Evaluation Team observed that it was not possible to tell who are being referred to what service by whom. First, the WHCs and individual groups of outreach workers are interested to know the number of persons referred by ward and respective outreach worker. Second, it would be interesting to know who is or is not complying with the referral and is reporting to the health facility or provider as recommended.

Recommendation #6: *Concerted efforts should be made to track and monitor referrals both at community and facility level to better understand the magnitude of and compliance to referrals made by WHC, PPs, CHVs, Imams and TTBAs. It is suggested that this might include referral slips that would be color-coded by type of worker referring and include such information as the patient's name, name of the referral agent, ward number and date. A box would be provided to the service delivery points for collection of these referral slips that would be collected by a MHD staff member at the*

end of each month, analyzed, recorded and reported on a monthly basis to the wards and quarterly basis to the MESPCC for sharing at their regular meetings.

♦ ***Mortality*** – The numbers of annual births in the CSP project area is too small to allow for meaningful calculation of infant, child or maternal mortality rates. One death less or more would result in rates that are unrealistically low or high. In other words, they would not be useful. Instead, Concern Worldwide Bangladesh and the CSP correctly decided to focus on a set of intermediate or outcome indicators. If good progress is made in these indicators, it can be safely assumed that mortality will be reduced in all target population categories in the near future.

Nonetheless, the population-based data is maintained by the CHVs and retained by the WHCs. Priority is given to reporting deaths of under-fives and mothers. This makes it possible to track deaths by age and reported cause. According to a review of the minutes of all the WHC monthly meetings from Saidpur and Parbatipur between October 2003 and June 2004, two mothers in Parbatipur and 10 infants (4 in Saidpur and 6 in Parbatipur) and one child (in Saidpur) died. One mother reportedly died of eclampsia while the other died at home as the result of an abortion. The fact that there were no maternal deaths in Saidpur over the previous year was reported in the national paper, the *Daily Star*, on 26 April 2004[4] (**Attachment XII**).

The one child death, a two-year old female, was due to diarrhea. Of the 10 under-one deaths, eight were female. Two were reported to have died of accidents, two from unknown (one of these was from a "non-user family"), one from "congenital defects", three from malnutrition, one from pneumonia and one neonatal death whose mother was a "resistor to TT, ANC and was delivered by an untrained TBA". The causes of death are questionable and details describing the social cause of death (i.e., where the system failed) are limited. There is also a need for each municipality to roll up the mortality data from their respective WHC so that they can identify trends and explore causes and determine ways to intervene, improving such factors as access, quality of services, knowledge/behaviors, community action.

Recommendation #7: *Revise and formalize the mortality review process to improve the understanding of medical and social causes of death so that appropriate corrective actions are taken to strengthen the local program.*

B. Capacity Building – Municipality

For health practices and status to be improved in Saidpur and Parbatipur, it was necessary but not sufficient to strengthen the knowledge and capabilities of the health providers. So that the municipalities were able to manage, coordinate and sustain a health system that responded to population needs, the CSP built the capacities of the municipal bodies to

[4] The minutes of October 2003 from Ward 13 in Saidpur report that one woman died as a result of postpartum hemorrhage, but she was staying at her parent's house outside the municipality at the time of death.

deal effectively with health matters. Municipalities consist of three elements: the Cabinet (elected Chairman and Commissioners or heads of the WHCs), the Municipal Health Department and the MESPCC.

Concern Worldwide Bangladesh pursued their objective by investing considerable time and efforts advocating, orienting and training municipal authorities in the two urban centers. At first, health was not on their agenda at municipal meetings and the officials did not welcome Concern Worldwide Bangladesh's participation in their meetings. Slowly the CSP succeeded in building a relationship based on respect, confidence and trust with both municipal chairmen who are responsible for any health program since they headed the Municipal Central Health Committee (MCHC) which, according to an MOLGRD circular in 2002, became the MESPCC (Municipal Essential Services Package Coordinating Committee).

The CSP **training** for the municipal cabinets was intense. It consists of a total of 13 days divided into four sessions. The first three-day course focused on the role and responsibility of the municipal cabinet members and reviewed the statutory duties and operational mechanisms of the health program. While the municipal authorities were unaware of the 1995 statute mandating the formation of a Municipal Central Health Committee and the MOLGRD had made no effort to ensure that the body was constituted or functioned, the CSP assisted the municipalities to form the committees as a means to coordinate all the local health partners. The CSP took something that existed only on paper and turned it into practice.

The second training lasted two days and concentrated on priority basic health messages that would serve as the core of the CSP. The cabinet members learned about EPI, vitamin A, diarrhea, ARI/pneumonia, safe motherhood as well as communications and social mobilization. This was followed by a three-day training on the concept and elements of participatory planning and how to develop and monitor a participatory action plan. The fourth session is planned for September and will last for five days; it will involve local level advocacy and policy formation to support CSP's intention to bring what has been learned in Saidpur and Parbatipur to a wider audience. The content of all these trainings was new to the cabinet members, but it was delivered in a participatory manner and raised enthusiasm at the same time it was raising awareness. It became clear to the municipal leaders what the mother- and child-related health problems were and that it was their responsibility to do something about them. Simultaneously, the trainings spelled out what the municipality could do, and the human resources that were available, to improve the health status of their constituents, making them aware of their roles and responsibilities.

1) <u>Results</u>: One of the unique features of Concern Worldwide Bangladesh's CSP is that it not only realized the importance of the capacity-building process, but it established a means to monitor it. This is important for several reasons. First, the concept of capacity is not easy for the participants to grasp since it is "soft", rather amorphous and ambiguous, making it hard to grasp and harder to track. There are a number of tools available to measure organizational capacity (e.g., the Organization Capacity Assessment

or OCA, the Institutional Strengthening Assessment or ISA) which Concern Worldwide US and Bangladesh referred to in the development of their Health Institution Capacity Assessment Process (HICAP). This has proven very useful to the project in several ways. One, it provides a means of monitoring the strength of the municipal cabinets. Moreover, by involving cabinet members in the selection of the components to be monitored and the definition of each, they have ownership as well as an appreciation of what they must do to be successful. The HICAP focuses attention on six important elements required for an effective organization. By periodically assessing their capabilities in these six areas with the help of a facilitator, the body is able to see how they are doing and identify aspects where they must strengthen themselves if they are to improve their score. In other words, it makes something very abstract into something that is more tangible and comprehensible.

The HICAP is a participatory approach utilizing Appreciative Inquiry (AI) that seeks out the best of what is to help ignite the collective imagination of what might be. AI sees human systems as creative and innovative, hence full of solutions. To lead an organization in the direction of change, AI uses the "4-D Model" – Discovery (what happens when an organization is at its best), Dreams (what might be), Designs (ways to create the ideal as articulated by the whole organization), and Delivers (ongoing process of realizing the organization's potential).

The Organizational Development Unit (ODU) of Concern Worldwide Bangladesh facilitated a capacity assessment and identified a number of components that were considered important for the effective operation of the MCHC, a body that consisted of the Municipal Chairman, *Upazilla* Health and Family Planning Officer, Health Inspector, Health Assistant, Municipal Health Workers, all the Ward Commissioners – whoever played a role in the provision of health care in the municipality. Originally the capacity areas and definitions were developed in an organic manner as municipal capacity in health was a national innovation and there were no pre-existing definitions. Over time commonalities across the two municipality visions and priorities became more apparent and consensus was reached so that it was possible to provide a structure for focused capacity-building discussions, monitoring and comparison.

After the definitions of the components were agreed upon, the participants discussed and decided on the present status of the organization in each of the capacity areas. The categories were consolidated and ended up with six (leadership, coordination, participation, resource mobilization, human resource development, and monitoring and evaluation). The group's performance on each element was ranked according to an assessment scale consisting of six levels represented by a tree growing symbols (starting with seed sowing and progressing through germinating, sapling, maturing, flowering and fruit bearing stages). **Attachment XIII** is the HICAP 2004 report.

The progress achieved by the two municipalities was excellent. As **Table 6** shows, Saidpur and Parbatipur are now able to operate more effectively on their own, leading, managing, promoting and coordinating the work of all the partners.

Table 6
Capacity Assessment of Municipality Authorities

Capacity Areas	Elements	SAIDPUR		PARBATIPUR	
		2000	2004	2000	2004
Leadership	Skilled effective and accountable leadership established with consultative decision-making culture and alternative leader mechanisms in place to ensure planned programs are being properly implemented	1	3	1	4
Coordination	Friendly & effective relations established with public and private heath partners through good inter-departmental communication for implementing planned programs of the health department by delegating responsibilities to ensure quality health services for the people	0	2	0	3
Participation	Achievement of health objectives through spontaneous involvement of like-minded institutions and individuals (male and female) having mutual trust, cooperation, respect and sharing the successes and failures.	1	3	1	5
Resource Mobilization	Optimum utilization of existing facilities through active participation of the Municipality and all concerned persons, organizations and establishments towards smooth implementation of the health activities for people's welfare.	0	3	1	3
Human Resource Development	Presence of need-based training, increased staff work-skill/efficiency, HR development system in place with current staff appraisal process in place.	0	3	0	3
M&E	Regular assessment of the progress of the activities of the health department as per plan, disseminating among the people, taking necessary steps for achieving next target and the final process of assessing the achievements at the end of a specific period.	0	2	0	4
OVERALL Capacity Score		**0.33**	**2.67**	**0.50**	**3.67**
AI Scale Overall Classification		Seed sowing	Sapling/ maturing	Seed sowing	Maturing/ Flowering

(Note: Used a 0-5 point scale, 0 representing very weak and 5 very strong.)

Recommendation #8: *Facilitation of the WHC assessments each year should be provided by MHD staff who is responsible for another ward to ensure objectivity. This should continue to rotate (e.g., the health worker assigned to Ward #1 would facilitate the assessment of Ward #2 one year, Ward # 3 the following year while the MHD staff who usually works in Ward #2 would be responsible for facilitating the assessment of*

Ward # 3 one year and Ward # 4 the following year). This will increase objectivity as well as increase the sharing of experience and expertise among the municipal staff and wards.

2) Findings: The Evaluation Team found that the Concern Worldwide Bangladesh and the CSP have made, as in the case of the Municipal Cabinet, MHD and the WHCs, considerable progress building the capacity of what was originally referred to as the MCHCs. There is also the Municipal Cabinet consisting of the elected public representatives and headed by the Municipal Chairman. In the first several years of the CSP, the MCHCs were the weak link with the WHCs and municipal health departments having been strengthened and more strongly committed. In 2003, with the assistance of JSI-Bangladesh, CSP focused on building the capacity of the MESPCCs (as the MCHCs were renamed by the MOLGRD) and turned them into effective bodies to coordinate the existing health resources in the municipality. They succeeded in turning an MOLGRD mandate from paper into practice.

The Chairman provides the leadership and convenes the MESPCC membership each quarter. Although not specifically stated in the circular, both MESPCCs in the CSP have co-opted the ward commissioners to attend, including them in all discussions since they were an integral part of the municipal health team and municipal-level authorities could materially affect them and their communities. To ensure continuity when the chairman is not available, the MESPCCs promoted alternative leadership whereby authority was delegated to a panel of three leaders, a traditional structure. Progress was made in terms of consultative decision-making, running better meetings (e.g., providing agendas beforehand, maintaining minutes). Strong leadership was demonstrated after the recent elections when both incumbent Municipal Chairmen were replaced. Despite the change in leadership, there was little disruption in the MESPCC operations since the alternative leadership was there to provide continuity and orient the new Chairman.

Coordination was also improved. One of the commissioners was selected as Health Convener and this has been a key factor in the success in coordination. All relevant stakeholders were included in the quarterly MESPCC meetings. The group successfully organized rallies and health events for a variety of national and international days, good for promoting and reinforcing health messages in support of maternal and child health issues, particularly among the male population.

There were a number of examples where MESPCC members worked together to improve health services. In Saidpur, supplementary medical staff and sweepers were assigned to the 50-bed Hospital by the MESPCC. In Parbatipur, LAMB Hospital, located four kilometers outside the town, has made an offer to the MESPCC to establish a satellite clinic in the town to provide more accessible services to the urban population. A concern raised by the MESPCCs recently is an order by the MOHFW that instructs them to establish a separate GAVI committee to manage the Taka 10,000 (approximately $165) they are and will be receiving each month for the next five years to support immunization activities. The feeling in Saidpur and Parbatipur is that this work naturally falls within the purview of the MESPCC and another committee would be redundant. The MESPCC

members also mentioned the fact that the separation that exists between the health and family planning sections of the MOHFW in Dhaka often affects coordination in the field. They suggested that coordination could be strengthened at the municipality level.

Recommendation #9: *All new health programs/initiatives should be coordinated through the MESPCC to ensure maximum participation of all stakeholders and optimize cost-effective implementation.*

Recommendation #10: *Both wings of the local MOHFW operations should be engaged in local programming through the MESPCC right from the beginning to ensure effective coordination and collaboration in new municipalities.*

Participation at MESPCC meetings is high. Instead of attendance declining over time, rates are increasing. The longer the MESPCC is around, the more stakeholders realize its importance in achieving individual as well as group objectives. In addition, each member is individually contacted and reminded of the meeting, alerted to the agenda and encouraged to attend. It helps that the date of the meeting is set (e.g., the first Monday of every third month) so that members can put it on their calendars well in advance and attempt to keep the date open. In addition, individual MESPCC members have recently negotiated and signed individual Memoranda of Understanding (MOU) spelling out and formalizing their respective roles and responsibilities. These are expected to keep participation high and sustain MESPCC effectiveness in the future.

Resource mobilization has proven to be one of the areas where the MESPCC and their leaders have excelled. Budgets for health have increased in both municipalities, especially Parbatipur where annual figure has gone from Taka 15,000 (US$250) for 2000-2001 to Taka 120,000 (US$2,000) in 2004-2005. This does not count the funds to pay the 11 new municipal health workers that the Chairman added earlier this year that nearly doubles the amount. The newly elected Chairman has increased the monthly salaries of these Master Role[5] employees from Taka 700 (US$11.67)/month to Taka 900 (US$15)/month. In Saidpur, the budget for health has also been increased over 16% in the last four years and the new Chairman has begun paying each of the municipalities 15 wards Taka 200 (US$3.33)/month (Taka 100 to support the monthly meetings of the CHVs and WHCs). Both of the new Chairmen talk of their intention to collect outstanding taxes and payments. In Saidpur, over half the households owe taxes and when combined with trade licenses arrears, unpaid rent on municipal buildings and unpaid bills from the railway, Biman (the national airline) and others, the total comes to over US$1.4 million. They thought that the political cost of collecting unpaid taxes may be outweighed by the appreciation for and positive impact of the health program on the community.

There has been significant human resource development in the two municipalities under the CSP. In addition to the training of the MESPCC and MHD staff, job descriptions for the various positions in the MHD have been developed and performance reviews have become standard practice. Everyone familiar with the performance of the municipal

[5] Master Role employees are considered casual employees, not tenured.

health workers over the years have pointed out their greatly improved morale. They are empowered and proud of what they can do after their training and the roles they are playing in support of the WHCs and it members. They mention themselves the increased job satisfaction they are getting from their work. They can see change happening and know that they are at least partially responsible for that. Their work was being recognized and acknowledged. The best illustration of the dedication of the MHD staff can be found in Saidpur where the 18 Master Roll workers were unpaid for 17 consecutive months in 2003-2004 yet continued to report for work everyday and do their work with enthusiasm.

There are several examples of how municipal capacities were developed in monitoring and evaluation. First, the municipal health staff worked with the CSP team in conducting recent Lot Quality Assurance Sampling (LQAS) data collection for the final KPC. They are now able to carry out such exercises on their own which will help them determine in the future if the program is working at the ward level and where additional support is required. Another example is the HMIS that the municipal staff recently helped introduce at the ward level. This population-based system includes an enumeration of the entire population and was time consuming to establish, but now that it is operational they see how it helps the program and is not too cumbersome to maintain. It is valuable in that it provides the wards and the volunteers with information on births and maternal/infant/child deaths, immunization (by antigen), vitamin A coverage, ANC, place and attendant delivery, postnatal care, ARI/diarrhea/pregnancy referrals and modern method contraceptive usage. Quarterly compilation of data is utilized by the MESPCC as well to determine where corrective action is required. For example, in Parbatipur it was noted that two wards had lower contraceptive prevalence so additional staff were allocated to these wards to carry out additional motivation. This was data for decision making in action.

C. Capacity Building – Community/Ward

While all three components of the CSP partnership are vital if the strategy is to be effective, one is tempted to say that the community is the most important. It is here that the felt needs are expressed and services are delivered. This is where the program and target population intersect. The community members must participate if program objectives are to be achieved. As learned in the CSP and many other projects, nothing is possible without the community. It is also true that anything and everything is possible if the community has been properly oriented, organized and mobilized.

The CSP's objective was to activate an organization at the ward level and build its capacities to manage and sustain health activities involving a number of key partners. This was to be achieved through the formation of the Ward Health Committees, bodies that were mandated by an MOLGRD circular in 1995. Once again, as in the case of the MESPCC, the project has been able to take something from paper/policy and put it into practice.

Ward-level activities started with a PLA exercise with important target populations (e.g., pregnant women, TBAs, fathers). This qualitative information gathering was done while the quantitative KPC baseline was conducted. The results of both were analyzed together. Then advocacy was carried out with the ward commissioners, and WHCs were established by identifying appropriate community members who would be most active at serving their neighbors and promoting improved maternal and child health practices. The success of the CSP was built on constructing a strong foundation based on human capital. The process was intensive and took time, as much as six to nine months in the first several municipalities as the methodology and orientation mechanisms were being developed. Capacity building at the community level included a two-day course on basic health messages for the WHC members. Another course of two days for WHC office holders focused on leadership, institutional development, resource mobilization, office management and planning. Other trainings were carried out for individuals involved in community promotion activities, the CHVs, Imams, primary teachers and TBAs, plus negotiation sessions on IMCI for private practitioners.

1) Results: The CSP demonstrated that **WHCs** can make significant contributions to improved health at the community level. As a result of capacity-building efforts, the WHCs are able to manage a number of local change agents and achieve a high degree of independence after developing organizational capabilities and health knowledge and skills. As in the case of the MESPCC, the CSP developed and introduced a means to determine and monitor organizational effectiveness and strength of the WHCs. This enabled the leaders and members to appreciate where they and their WHC was in terms of becoming a viable organization, while helping them conceptualize what was required to have a good organization. They participated in identifying and defining the elements of an effective organization. The organizational capacity of the 24 WHCs was tracked through facilitated self-assessments on several occasions and significant progress was evident as can be seen in **Table 7** that shows the improvement between 2003 and 2004. **Attachment XIV** is the WHC 2004 report.

Table 7
Capacity Assessment of WHCs

Capacity	Elements	Parbatipur		Saidpur	
		2003	2004	2003	2004
Leadership	Presence of strong leader with alternative leadership structure committed and motivating all members to achieve local health priorities.	63	76	78	85
Planning	Documented and monitored activity plans with timeframe exists with broad consultation ensuring maximum utilization of local resources according to the necessity of the locality and importance.	67	80	70	76
Coordination	Established relationships with the public and private health system who are adhering to agreed roles and responsibilities.	60	74	65	74

Capacity	Elements	Parbatipur		Saidpur	
		2003	2004	2003	2004
Participation	Recognized importance of broad participation and promote opportunities for participation of all social strata as well as gender in community health promotion.	54	72	71	75
Human Resource Development	Identified needs for WHC, CHVs and TBAs, plan and resource trainings, system for performance recognition.	68	82	66	78
Local Resource Mobilization	Identified and effectively use different public and private health service providers, local political and opinion leaders, and fund collection to serve community health priorities.	61	79	53	74
Financial Management	Bank account designated to WHC, maintenance of transparent income and expenditure, and policies and fund use adhered to.	64	76	68	72
Monitoring and Evaluation	Regular monitoring of work plan and health information system and participation in periodic program evaluation.	60	75	65	74
Overall WHC Capacity		**63**	**76**	**67**	**76**

The WHCs and MESPCCs analyze the disaggregated data to identify which WHCs are functioning below the norm and require additional support or refresher training. The individual WHCs are able to see where they have to improve themselves in order to raise their performance and overall score. They also see where they are relative to other wards in the municipality, fostering a degree of healthy peer competition.

The capacity-building monitoring systems for the municipal and ward organizations differ in number of components tracked and in the scoring scale. This can lead to confusion for the ward commissioners who are involved at both the municipal and ward levels.

Recommendation #11: *The municipal and ward capacity-building assessment tools should be merged into one using the same number of capacity areas and scoring system. The indicators and their definitions should be harmonized and standardized and guidelines developed.*

2) Findings: While the contributions of the various local resources persons who participate in the WHCs have been mentioned, it is important to look a little more closely at each of them.

♦ **CHVs** – Most international community health specialists would be tempted to dismiss the CSP CHVs on several counts. It is thought to be necessary that if volunteers are to be effective in safe motherhood and family planning, they should be older females and married to be credible. The CHVs do not qualify, although they are largely (approximately 70%) female, they are young (usually secondary school level) and

unmarried. CSP experience shows that the energy and enthusiasm of the students more than makes up for what they lack in terms of their marital status and age. They typically collaborate with the local TTBA if they have to deal with a sensitive topic or issue in a particular household.

International experience and thought would also be concerned about the CHV drop-out rate since they are volunteers receiving no financial compensation or even training per diems during pre-service training or monthly refresher meetings. Again, the CHVs have proven to be positive deviants. The project refers to their CHV "turnover rate" since whenever a CHV has to leave the program, there is someone who has worked alongside for a number of months who is ready, willing and able to step and take the CHV's place. The WHCs usually have the luxury of having several candidates to select from. Thus, there is no drop-off in program performance. As **Table 8** shows, the CHV turnover rate has fallen since the first year of the program and for the most recent year is below 10%.

Table 8
CHV Turn-Over Rate

Year	Parbatipur			Saidpur			Total		
	# CHVs	Turn-Over	%	# CHVs	Turn-over	%	# CHVs	Turn-Over	%
2000	163	22	13.5	191	58	30.4	354	80	22.6
2001	222	48	21.6	265	40	15.1	487	88	18.1
2002	208	31	14.9	317	36	11.4	525	67	12.8
2003	213	11	5.2	401	42	10.5	614	53	8.6

The explanation given by CSP members is that the selection of the CHVs has improved. Originally many of the CHVs were taken from the ranks of the NID volunteers. Some of them were not found to be effective or committed. As they became inactive or less active, they were replaced by the WHCs with students. There are a number of causes for CHVs turnover – getting a paying job, going on to higher education, getting married and leaving the community, moving out of the area with parents. Earlier this year in Parbatipur, 11 CHVs were hired by the municipality to work with the MHD as paid staff. They were logical candidates since they were trained, experience and committed. At community level, new CHVs were recruited to take the place of the 11 newly promoted CHVs.

Because the CHVs are young and a large majority of them females, the WHCs meet with the candidate's parents prior to appointment to explain what their responsibilities will be and that they will be doing important work on behalf of their community. This is considered very important in a conservative society like Bangladesh. A CHV is only allowed to work with the WHC if the guardian agrees. The CHVs cover anywhere from 20 to 90 households that are located in the neighborhoods where they reside. The CHVs interviewed work from three to eight hours a week on CSP/WHC activities.

Box #1
From CHV to Municipal Health Worker

Ratna served a CHV in Ward 5, Parbatipur for two years. She worked hard and was highly respected by the approximately 50 households she regularly visited in her neighbor-hood. Because Ratna demonstrated a high-level of energy and good knowledge, the MHS.
recruited her to join their ranks as a paid employee. She is now 20 years old and has completed her secondary education. While participating in the health program, Ratna has been trained in and is capable in C-IMCI, EPI, Vitamin A, maternal & newborn care, HMIS and LQAS. Her dedication and constant smile are indicators that she is not only contributing to the betterment of the community, but has become a competent and confident young health professional.

The CHV to household ratio has not been a problem in Saidpur and Parbatipur, but in the future the ratio should be a more standardized. In the larger municipalities the temptation to appoint fewer CHVs to more households should be resisted.

Recommendation #12: *In the extension phase of the CSP, one CHV should be selected for every approximately 50 households.*

♦ **TTBAs** - The important role of the TTBAs has already been mentioned. However, it should be stated that the TTBAs are delivering fewer infants these days as they refer more and more mothers to health facilities for delivery. They appear to be erring on the side of caution, which is to be commended. The TTBAs will remain a vital part of the local health system. With their lower delivery load, a modified role for them might be considered – e.g., as a support person for several CHVs, giving the latter the credibility they lack due to their age and the fact that they are unmarried.

♦ **Imams** – The participation of the Imams is important from several different perspectives. First, they support the messages being disseminated by the CSP by explaining them to the members of the WHCs and community in a religious context (e.g., support from the Holy Quran for breastfeeding up to two years of age). They are also helpful in getting the messages across to the male population. One example given is Imams mentioning different maternal/child health practices several times a month at Friday prayer, attended exclusively by males. They also take part in national/ international days and preside at "Best Father" award presentations. Imams are periodically called on to visit resistor households and discuss with the husband why the maternal/child health interventions are being promoted and what dangers exists if that family does not do as the CHV and/or TTBA suggest(s). They are an important part of the ward-level health team.

♦ **Teachers** – Involvement of primary school teachers in the CSP has strengthened the existing school health program. In addition, their CSP participation, as community influentials, has lent credibility and status to the program and the messages being promoted. The Evaluation Team learned that a third of the WHCs have also appointed secondary school teachers to their ranks. This is important to focus more attention on adolescent issues, including HIV/AIDS and nutritional status (especially anemia) among

the young females/future mothers. There is a perceived need to help young women prepare themselves physically and mentally for child bearing.

Recommendation #13: *WHCs should be encouraged to add a secondary school teacher to their membership and they should be part of the team in new WHCs (along with primary teachers).*

♦ **PPs/RMPs** – Youssef Tawfiq (2003) and Jean Capps have carried out a thorough investigation of the PPs and their role in the CSP to date. Some of the highlights of her work are included here to highlight what has been learned about the PPs in the last several years as they have been involved as a member of the community-level health system. The CSP involvement of PPs is described in the first section of this chapter. Although not quantifiable, it appears that PPs have increased referrals for severe child diarrhea and ARI. Now that they know the risks associated with these diseases, they are more willing and eager to refer; they do not want to held responsible for a child dying. The PPs' counseling skills have improved, especially relating to increased fluids which, as was seen, was one aspect of care-seeking knowledge that showed a great increase over the last four years. Along with better linkages between PPs and health facilities comes a better working relationship with the health system, more respect and appreciation for their work. This experience is similar to what we have seen with the TTBAs. This has been an encouraging beginning. In addition to the recommendation mentioned earlier to include homeopaths in the program and to initiate a referral tracking system, Capps has made several recommendations, including the development of some job aids to remind the PPs of the important information and the appointment of one person in each MHD who will serve as the point person for the PP activities.

_ **Commissioners** - There is some limited evidence that active CSP involvement played a role in the recent **elections** for ward commissioners. In Saidpur, 10 commissioners were re-elected – of these, eight were heavily involved in community health promotion and two played a more limited role. Of the five newly elected officials, one prevailed over an incumbent commissioner who was not very active while the other four defeated commissioners who scored well in terms of involvement. In Parbatipur, three commissioners were reelected, all with good health performance records. Out of the six newly elected commissioners, four followed poorly performing officials and the other two triumphed over commissioners who had performed well. It is worth noting that all three female greater ward commissioners (covering three wards each) were re-elected. It will be interesting to see if **civil society** plays an increasingly larger role in the CSP in the future and if elected officials learn that they can do well (politically) by doing good (for the community). In such a case the political system would work in favor of the community, encouraging (and rewarding) politicians for doing things for the right reason.

_ **Very Poor** - One finding of the Final Evaluation is that the CSP has done well in reaching the poor. This is an area that Concern Worldwide has focused considerable attention on in Bangladesh and internationally through a variety of programs in all sectors. In the CSP, the WHCs have devoted considerable thought and energy to include the less advantage segment of the community and have had some success in working with

the poor through a variety of out-reach efforts. There are many stories of how the WHC identified needy households and assisted poor families who required a service like Cesarean-Section at a facility like LAMB but could not afford the cost. One example was an emergency C-Section that cost Taka 7,000 (US$117). The WHC negotiated with LAMB on behalf of the needy household and had the charge reduced to Taka 2,000. To cover this amount, the family paid Taka 500, Taka 800 was taken from the WHC fund (one of the reasons for which is support to the poor in the community) and the final Taka 700 was raised from additional community contributions.

The WHCs maintain lists of the poor living in their jurisdiction. All the committees visited had a list but a question remains about how accurate they are. The program guidelines were not very helpful since they specify households should earn less than Taka 30 (US$0.50)/day and have two or less meals a day. This includes a large portion of the community. The WHCs have come up with their own lists of poor households but it is unclear what they mean. For example, one ward in Saidpur had two lists – one that was developed when the government wanted to distribute food and half the households in the ward were put on the list. The rule was: when in doubt, include on the list. The second list was a response to an offer of assistance in the form of blankets, but was limited to 60 names. So the WHC listed 60 names and stopped. Neither list was helpful in identifying the very poor households which require special efforts to ensure they know and really believe that they can access the health services to which the WHCs are supposed to link all community members.

The Evaluation Team found evidence that like most development programs, the CSP has not been able to fully penetrate and integrate the **Least Advantaged Group** (LAG). An illustration of the resulting problem was a very poor woman who was pregnant and suffering from a breach presentation with the prospect of a difficult delivery. She went to LAMB and a C-Section was prescribed. She heard from others that there would be a high cost for the operation since it was a private hospital. Because she knew she was unable to pay the amount, she returned home and she and the infant died. This was a case where the support system (i.e., community safety net) did not function because the woman was not included in it, hence was not aware that the WHC had several mechanisms to assist her. The discussion based on the birth preparedness card would have prevented this unfortunate situation by ensuring the family knew before delivery what the WHC could do on her behalf.

This case and others demonstrated to the Evaluation Team that, while the Concern Worldwide Bangladesh and the CSP have made good in-roads to reach the poor, there is more to be done. For every two or three stories of a poor family helped through the CSP, there is a story of what in Bangla are called the “ekdam poor” (i.e., poorest of the poor) who has fallen through the CSP safety net. The constraints that prevent the very poor from accessing services are both social and economic. Some groups (e.g., sweepers) are self-excluded, despite efforts made by programs to support them (expose them to behavior change messages, ensure financial support, facilitate negotiations with health providers). If not socially excluded, there are the extremely poor who lack a feeling of efficacy; they do not believe that they have the right to have access to the services. They

are the marginalized segment of the society that exists on the social and economic periphery. Historically, all development sectors have been unsuccessful in effectively reaching the poorest of the poor. Nonetheless, the Evaluation Team feels that Concern Worldwide in Bangladesh, with its multi-sectoral approach and its commitment to the poorest segment of society, has the potential and the opportunity to make a contribution by focusing attention and resources on this problem in the CSP.

Recommendation #14: *A specialist should be hired by Concern Worldwide Bangladesh /CSP who would focus full attention on reaching the LAG. This person would have to define who the LAG are, identify them and where they reside, and determine how to involve them in the program. There is a need for more quantitative/specification of this group and how the health structure can effectively reach/include them. In addition, this person should develop guidelines for the WHCs on how to develop a useful list of the LAG, including establishing appropriate criteria and eventually solutions/mechanisms to ensure the poorest of the poor have access to the knowledge and services that everyone else in the community does.*

The **annual planning** exercise is in place at both the WHC and municipal levels and there was an effort to track progress on the achievement of objectives in these plans on a regular basis. At the same time, there was evidence to suggest that the WHC plans were routinized to some extent, i.e., the same or very similar activities were found on most of the WHC annual plans and from what the team was told, the municipalities had provided examples of activities and wards included same or similar activities in their own plans. In some cases this might make sense; in others, it may not. This was not the original vision for the way annual planning would be done (i.e., plans were to be sent to the municipality from the wards based on their priorities and the result of local engagement and participatory decision-making with the residents they represent).

Recommendation #15: *The project should develop guidelines for WHCs on participatory (i.e., how to identify local priorities) annual planning, practical tools and monitor how it is being implemented; it should be included as a component of the capacity self-assessment exercise. Municipal authorities should be enabled to compile a municipal plan that retains the unique priorities of the respective member WHCs.*

Another finding involves the ability of the WHCs, primarily the CHVs, to collect and maintain household health data. As described, the new **HMIS** is providing the WHCs with the most important information they require to monitor the health practices, coverage and status of the mothers and under-five population of their community. While all relevant actors in the HMIS (WHCs, CHVs, MHD staff) currently expressed interest in the process, it will be interesting to see how long and how well it is maintained. If it survives, the CSP model will have proven most unusual, if not unique.

D. Cross-Cutting Issues – Training, Behavior Change, QoC and Sustainability

There are a number of cross-cutting issues that relate to all three components of the CSP – the health services, the municipal authorities and the community. These include training, behavior change, quality of care and, very importantly, sustainability. Rather than addressing each of these themes under each of the components above, we think it is helpful to examine them across the project components.

_ **Training** - The CSP conducted a huge amount of training, a total of over 45 person years. Attachment IV summarizes the content and length (number of days) of each course plus the number of people who were trained. The training modules and lesson plans have all been developed, field-tested and found to be effective. The trainings are practical and highly participatory. These training curricula and materials are now ready for use in the expanded program in the seven additional municipalities. It will be necessary to condense and streamline the trainings as the approach is replicated and greatly increased populations are included. For example, the orientation training for the municipal MESPCC chairmen has been reduced from 13 days to four. Of course, the project must be constantly vigilant of the trade-off between the demands of expansion and the commitment to quality and effectiveness; the process should be monitored and adjustments made if results begin to falter. Somehow the blueprint/"cookie cutter" approach and the tendency to routinize must be resisted so that the important process is not compromised.

The **health team**, consisting of the community volunteers, the private practitioners and the municipal health staff, has been instrumental in reaching project objectives. Several of these partners deserve special mention. First is the Municipal Health Department (MHD) staff. This group is paid (albeit irregularly) and consists of Health Inspectors and Health Supervisors, plus a staff on the Master Roll (i.e., work for the municipality and are considered "casual labor"). Traditionally the municipal health staff has been thought of as being minimally qualified and ineffective. However, since being trained by the CSP and included as part of the urban health effort, they have become effective, contributing members of the team. As observed in other projects (e.g., Tanzanian Child Survival and Development Project), public health officers are energized when the community is mobilized and made aware of health issues. It also demonstrates that workers are only as good as the system within which they work. If the system is no good, they will not be able to do their work properly and become demoralized. It is interesting to note that for all but a few months, both municipalities have been without a Medical Officer (MO) during the four years of the project. While it would have been advantageous to have an MO as part of the team, it turned out not to be necessary; positive results were achieved without an MO.

_ **Behavior Change Strategy** - The behavior change strategy developed by all stakeholders has greatly contributed to the achievement of the health objectives as it provided focus and consistency of health messages and reinforced through multiple local channels. All outreach workers and all CSP materials focus on the same issues/

interventions and utilize the same messages, eliminating the possibility for confusion created by mixed messages.

_ **Quality of Care** - The CSP during its final year initiated a Quality of Care (QoC) intervention to improve the performance of the MESPCCs and improve the quality of services. The Terms of Reference (TOR) were not as specific as they could have been leading to some variation in expectation. This issue is discussed further in Chapter IV on Project Management. There are demonstrated improvements in health facility staffs' behavior and attitude as well as cleanliness of the facilities following the Appreciative Inquiry intervention. However, the AI self-assessment had limitations as it did not cover some basic components for quality maternal and child health services (e.g., 24-hours Emergency Obstetric Care, or EmOC, services, availability of postpartum vitamin A).

Recommendation #16: *Appreciative inquiry tools, methodology and facilitation for quality improvement should be adapted so that they can also capture essential components of maternal and child health services (e.g. clinical, logistical and management). The QoC work should be continued and developed further.*

_ **Sustainability –** It is worth repeating that CSP did not create any form of dependency – neither in the form of financial nor physical inputs. It only built capacities and mobilized the community. The **recurrent operating costs** for what CSP has put into place are virtually nil. As recommended, Concern Worldwide Bangladesh should focus on and document sustainability issues in Saidpur and Parbatipur as they arise and are contended with over the next five years. Fortunately, the cost extension will allow Concern Worldwide Bangladesh to stay in close contact with the Phase One municipalities and learn/respond just as they have over the first four years. They have a plan to monitor the sustainability process and carry out post-intervention sustainability assessments utilizing methodologies and techniques being developed in conjunction with the CSTS Project.

An effective **supervision and monitoring system** now exists in the two project municipalities and will enable them to sustain the quality services and capabilities that have been developed. The MESPCCs and WHCs provide regular guidance and overall accountability. This internal accountability, much of it coming from below (i.e., the community), is essential since there is no accountability from above due to the lack of ministerial supervision, support or guidance.

The municipality health departments practice supportive supervision, providing on-the-job training to field staff and volunteers. In addition, standard training modules and lesson plans exist for each cadre of staff and the municipal workers know how to utilize them if they have to train and orient new staff.

The **HMIS** that has recently been introduced will enable the staff to identify areas of weakness that require additional support and training. And the **MOUs** between different organizations (e.g., the MESPCCs) and service delivery entities has become an important

mechanism to maintain collaboration and accountability among the different stakeholders.

The skills of the **TTBAs** and their high level of motivation are being maintained and sustained by means of monthly follow-up meetings with providers from the nearby health facility where they review the number of deliveries and referrals and complications occurring since the previous session. Annually a health worker observes the TTBA's antenatal, delivery and postpartum practices and completes a performance checklist (developed by LAMB). They are also closely linked to and supported by the community through the WHCs.

The performance of the **RMPs/PPs** is checked on a bimonthly basis through a peer-monitoring system whereby "followers" simulate a child's ARI or diarrhea case and see if the practitioner makes the correct diagnosis and refers according to the training.

Each MHD staff member is assigned to a specific ward and develops a close relationship with his/her WHC and the associated volunteers (i.e., CHVs, TTBAs, Imam, PPs, teachers) residing and working in that ward. They convene and conduct monthly **CHV meetings** where the volunteers receive refresher training and new health messages are disseminated and old messages reviewed and reinforced.

The **structure and system** developed at the municipal level are highly sustainable since they were designed from the beginning to be sustainable. Concern Worldwide Bangladesh's role was time-bound from the beginning. Building the capacity of the local authorities so that they would be able to manage their own high-quality health services was the shared vision that drove the CSP. There were no inputs, neither physical nor monetary, that created any dependency in the municipalities. No physical infrastructure was constructed or equipment provided that will have to be maintained or increase recurrent costs. No salaries were given by the project that the municipality will have to assume when the CSP ends. This was a priority in one of the originally selected municipalities, Mymensingh, which resulted in the location being dropped from the program (see box). This had two effects. One, it eliminated a municipality that had an alternative vision, and two, it demonstrated to other municipalities that the CSP was different from other health projects. The municipal staffs in both Saidpur and Parbatipur appreciated the fact that the CSP was temporary and that they should not get used to any special expenditures. A story the MHD staff in Parbatipur is fond of telling involves the Health Inspector who on a hot July day during the LQAS data collection would not allow the purchase of bottled water for the team since he knew that such "luxuries" would not be possible once the CSP came to an end.

Box #2
Resources, Not Capacity

The newly elected municipal cabinet in Mymensingh in 1998 wanted material resources rather than capacity building. Their demands from the CSP included:

- salary from CSP funds for all municipal health staff;
- 7 ambulances;
- 21 health centers, one in each ward; and
- motorcycle for health supervisor and bicycles for field staff

Another aspects of the CSP strategy that augers well for the sustainability of the model is the **leadership** structure that has addressed the issue of continuity and smooth transition when new chairmen are elected. In addition, the individual MOUs help ensure effective participation and functioning of the MESPCCs. The increased skills and resulting confidence and job satisfaction improves the chances of the municipal health staff continuing to do their jobs and doing them well. There is both ownership of and commitment to the program at the municipal and community levels. And accountability has been built into the program. While the system appears to be internally sustainable, there is always a concern that an outside **catalyst** would be helpful to keep things on track when Concern Worldwide Bangladesh is no longer available. More will be learned during Phase Two of the CSP as the program in Saidpur and Parbatipur are observed as they continue to operate according to the new partnership model.

Recommendation #17: *A qualified local NGO should be identified early in process in each new municipality adopting the CSP approach and mentored by the implementing organization (i.e., Concern Worldwide Bangladesh in this case) so that they can assume the catalytic role, thus enhancing replication and sustainability. The possibility of including an NSDP-supported NGO should be considered in the six of seven new municipalities where at least one NSDP NGO is operating.* ***Attachment XV*** *is a concept paper on how an NSDP-CSP collaboration would function.*

There is an identifiable need to **document** the lessons learned during both the sustainability phase and replication. Process documentation that examines all three elements (community, municipal authorities and municipal health service providers) would be helpful in guiding the ambitious undertaking. This is a function that will helpful for the person Concern Worldwide Bangladesh plans to hire to advocate on behalf of the community approach in urban health in Bangladesh. It is important that the donors and the public decision-makers are aware of and comprehend what has been achieved in Concern Worldwide Bangladesh CSP with the municipal and community partners and what the implications are for the other municipalities in the country. Meetings, site visits, a series of discussion papers would be helpful as part of the advocacy effort.

Recommendation #18: *The Advocacy Officer who is to be added to the Concern Worldwide Bangladesh staff in Dhaka in the expansion phase should also be responsible for the process documentation of the sustainability and replication experiences.*

When people hear the CSP health outcomes they are curious as to the **cost** of implementing such a program. This question is bound to come up constantly as the replication process gets underway and as interest grows at a national level. The start-up costs that included training course (curricula and materials) development during Phase One in Saidpur and Parbatipur are not representative. However, as the replication phase begins, it is worthwhile for Concern Worldwide Bangladesh to pay some attention to the costs involved in the orientation and training of municipal authorities plus the cost of establishing the system at the ward level. This would include setting-up the WHC and training the CHVs and other local volunteers (e.g., Imams, teachers, TBAs, PPs).

Recommendation #19: *Concern Worldwide Bangladesh should hire an economist technical adviser to determine and write a report on the costs of establishing a CSP-inspired municipal health structure and partnership so that clearer guidance can be provided to those interested in adopting the urban health partnership approach as developed in the CSP.*

To keep the CSP urban health model dynamic and continually evolving, the staff identified a need to have **exposure visits** both intra- (i.e., between CSP municipalities) and inter-project. They expressed a need to continue to share across municipalities.

Recommendation #20: *The CSP project should encourage and support the exchange of project staff between municipalities to maximize learning and sharing of experiences and innovative approaches.*

When one describes the CSP model to someone who is not familiar with it, they are typically skeptical about its chances to be effectively sustained. They doubt that the dependence on **volunteerism** can be maintained. They question how municipal residents will be able to access a health system that does not exist in urban areas. They are suspicious of a project consisting entirely of capacity building. The CSP is a multi-faceted, very complex project that is difficult to comprehend unless the person has had the opportunity to see it in action. The normal response is that once Concern US and Bangladesh withdraws, the structure developed in the CSP will slowly disintegrate and it is only a matter of time before the municipality will be back to *status quo ante*. Only time will tell where the truth lies, but there are aspects of the CSP urban health model and its community involvement that offer hope. There is an interlocking system of support and accountability that will go a long way to ensuring that municipal and ward activities continue. At some point, they should become institutionalized. How long that takes is yet to be determined.

Skeptics also point to the **experience with WHCs** in Bangladesh that does not make one optimistic. According to an official at the MOLGRD, those that have been formed over the past 10 years are generally no longer active or are only active when an NID is held. Why should the CSP WHCs be any different? First, as mentioned, everything that has been done in the CSP at the ward level was done with the vision of the ward being an independent unit that is integrated into the health system and structure that has been purposively constructed, linking it to a strengthened municipal health unit and a municipal organization that includes the major health service delivery partners. The WHC has developed a team of outreach volunteers who support and complement each other and to date have proven ready, willing and able to serve the community. The new HMIS gives the ward the data it needs to continue monitoring the health activities. The accountability for maintaining the operation is provided within the WHC and community. WHC leadership and continuity has been addressed by establishing alternative leaders that can step in when the commissioner is not there or when a new commissioner is elected. The WHC members themselves are very confident when asked about the chances of their activities being sustained.

Concern Worldwide US has worked closely with Child Survival Technical Support (CSTS) Project on the development of a Sustainability Index using synthetic indicators to monitor the progress of programs in achieving sustainability. The representation uses three indicators (health goals, municipality capacity and community capacity) and presents the results in the form of a triangle, making it possible to graphically present the current status and compare it to where the municipality was previously. All three indicators are based on quantitative data and are put on a five-point scale. In the case of the two municipalities, as illustrated in **Table 6**, Parbatipur is doing somewhat better at this point with a overall score of 4.7 compared to Saidpur's score of 3.7 (they had a 3 in the health goal because of a lower figures in a couple of the health results – like ANC visits, immediate breastfeeding and contraceptive prevalence). But the Sustainability Index makes it possible to see how both municipalities have progressed during the project; the results are positive and the basis for optimism.

IV. PROGRAM MANAGEMENT

The guidelines for final evaluation of USAID Child Survival and Health Grants includes a section addressing the PVO's program management – at headquarters, in the field, with partners and with the community. Strengths and weaknesses of the management support system are to be identified as they may have contributed to or hindered program implementation. Overall, the Evaluation Team found Concern Worldwide's management at all three levels (national, US and international) efficient and effective even though the CSP in Saidpur and Parbatipur represents the first Child Survival Grant Concern Worldwide US has received from USAID. A number of the management components relating to the field, partners and community have been addressed in the chapter on results/findings.

A. Planning

At every level, Concern Worldwide is committed to participatory planning. All stakeholders and partners are included in discussions and negotiations. This was the case in the CSP where all municipality authorities and municipal health staff participated in project planning and implementation giving them a high level of ownership and commitment. Recently the local partners were an integral part of the final CSP KPC. Concern Worldwide Bangladesh and the CSP have also involved the WHC members in all aspects of planning and helped build their capacity to do it for themselves in the form of annual plans at ward as well as municipal levels.

At the national level, Concern Worldwide has collaborated more closely in the last several years with MOHFW, NGOs, PVOs, international organizations (IOs) as well as USAID-funded Cooperating Agencies (CAs) and local technical institutions. For example, Concern Worldwide Bangladesh leads the C-IMCI Working Group and is an active member of the Urban Working Group. This provides the organization with opportunities to share what it accomplished and learned with other NGOs and government authorities, increasing the possibility of replication. In addition, the collaboration exposes Concern Worldwide Bangladesh to what others are doing and advances that are being made, innovative approaches and new techniques/methodologies.

Concern Worldwide Bangladesh has implemented the CSP according to plans and has been on time with most of its activities. The two aspects that have yet to be completed or are "works in progress" are the quality of care and private practitioners components. They were emphasized as part of the Midterm Evaluation that means that they were introduced into the implementation plan late. In addition, the nature of these two tasks makes it appropriate that they not be complete and are continued since they involve on-going processes and incremental learning.

While Concern Worldwide US and Bangladesh has kept to the original CSP plan, they have not been bound to it if there is evidence that there should be adjustments. For example, the work plan called for municipal capacity building before the wards. It became obvious to the project managers that the wards had to be developed first so that

municipalities could see and learn what needed to be done. The plan was modified accordingly and it turned out to be a wise decision. Another example of the need for flexibility involved working with health facilities. This was not included in the original CSP design, but as WHCs raised the demand for better quality services, this component was added.

The Concern Worldwide Bangladesh/CSP staff demonstrated an extraordinarily high level of skill implementing the participatory and consensus-building process. They integrated the Appreciative Inquiry technique effectively and were able to achieve remarkable success. CSP partners have learned these methodologies and techniques from Concern Worldwide Bangladesh and are practicing them themselves which augers well for sustaining program activities and results.

Concern Worldwide Bangladesh, as mentioned, is playing a significant role in the C-IMCI Working Group for Bangladesh and helped plan the national strategy. They have also taken the lead in developing a role for the PPs/RMPs to become a resource to help address common childhood illnesses and be integrated into the health system. This is a practical strategy based on data that shows that the majority of people go to these private practitioners first when their children become ill with diarrhea or ARI.

Field staff mentioned participating in a strategic planning exercise. All staff were involved in developing ways that new Concern Worldwide Bangladesh programs can affect government strategy. This affects the CSP that plans to place a high level of attention on advocacy in Phase Two of the CSP. This is appropriate and to be encouraged since what has been developed in Saidpur and Parbatipur is applicable to the municipal population throughout the country or over 35 million people. It may also be replicable in other countries since urban health is an increasingly important issue and one where much remains to be done. In addition, other countries are similar to Bangladesh in that municipal health is the responsibility of local government and not the Ministry of Health.

Challenges and Constraints – The planning for the almost six-fold expansion of the municipal health model will be a significant test and challenge for Concern Worldwide Bangladesh. This is a daunting task. Those responsible for leading and managing this effort are fully aware of the magnitude of this undertaking and are planning to phase some of the activities so as not to overload their capacities. Concern Worldwide Bangladesh's performance to date gives one confidence that they will manage the process effectively.

B. Staff Training

This is a real strength of Concern Worldwide, especially in their operations in Bangladesh. Institutionally they have a strong capacity-building orientation, working with over 80 Community-Based Organizations (CBOs) in Bangladesh. They are as exceptional at building the capacities of their staff as they are building the capacities of the target populations. They have provided their staff training in a number of areas,

including Positive Deviant (PD)/Hearth, Private Practitioners and their potential role in C-IMCI, LQAS, and Appreciative Inquiry. Concern Worldwide Bangladesh has a strong commitment to including the municipal staff in a number of these capacity-building trainings so that they are capable of doing the required task next time around. This was the case with the LQAS that was used in the recent KPC. The municipal staff that participated now have the skill required to do the survey in the future and will not have to depend on any outside person or agency to do it for them.

Concern Worldwide Bangladesh is an unusual organization having an Organization Development Unit (ODU). The Health & Nutrition Unit also has a Research Coordinator and several research assistants assigned to the project site who collect and analyze data. The skills possessed by these OD and research personnel are shared with others in Concern Worldwide Bangladesh, strengthening their capacities and project implementation.

Individual staff members described the training courses they had attended, including program in Bangladesh and aboard. They said that the staff career development was better than some of the bigger, better known international NGOs. The ODU and Senior Training Officer sits with individual staff members annually to develop a plan, identifying needs and possible training opportunities. Several project staff had the opportunity to attend training courses in the US in the past year – one at Centers for Disease Control and Prevention (6-week global public health strategy and management) and another at Johns Hopkins University (2-week Quality of Care). Staff received additional international training in Appreciative Inquiry, negotiated Practices with PPs (at Academy for Educational Development), PD/Hearth, LQAS and behavior change. When the individual returns to Concern Worldwide Bangladesh, it is the policy that they share with others what they learned, including innovative tools and techniques, so the broader organization benefits.

The Concern Worldwide US office has been very involved in support/collaborative groups like CORE and CSTS+. Concern Worldwide US is active on several CORE working group (e.g., IMCI, Social Behavior Change, HIV/AIDS, Nutrition). In addition, Concern Worldwide US's health specialist was elected to CORE's Board of Directors mid-2003. The organization has also worked very closely with the CSTS+ Project, especially on the measurement and tracking of capacity building and sustainability. The involvement with these groups has enabled Concern Worldwide US, a newcomer to the Child Survival Grants program, to benefit from the collective experience and gain some valuable technical assistance. This has helped Concern Worldwide US to strengthen its programming at its headquarters office and around the world.

Challenges and Constraints - The need was identified for more training in facilitation skills, report writing and documentation, financial management and use of computers. There is also a need for more project expertise in Quality of Care and quality improvement as Concern Worldwide Bangladesh becomes increasingly involved in the building of technical capacities in the larger municipalities. Skills in conducting Health Facility Assessments will help the Quality of Care aspect and permit the CSP to adopt the

methodology to fit program needs. The different QOC systems and supervision across the various service providers (e.g., NSDP, Marie-Stoppes, FPAB, MOHFW) will have to be harmonized, ensuring minimum standards in technical interventions. It would be helpful if key project staff members were trained in the John Hopkins QOC methodology during Phase II of the CSP. Moreover, it is important that several staff members be trained in IMCI, or C-IMCI if it is available, to support and lead the effort to upgrade care-seeking behaviors in ARI/pneumonia, diarrheal diseases and nutrition.

Another need that was identified during the Final Evaluation involves the development and management of technical assistance consultant contracts. Concern Worldwide Bangladesh successfully managed several consultancies during Phase I (e.g., LAMB training and study of impact, ICDDR,B for the development of the HMIS, KPS data collection and analysis, study of MESPCC and WHC capacity). However, the QOC contract with JSI/Bangladesh was particularly tricky since there was no established method to developing MESPCC partnerships or initiate a QOC approach among the MESPCC members. To be successful, the contractor along with Concern Worldwide Bangladesh had to collaborate closely as part of the process. A lesson from this experience was that more joint implementation and learning in such innovative endeavors would have been helpful. For example, Concern Worldwide Bangladesh/CSP could have hired their own Field Officer to work with JSI at the project level to better integrate with the CSP staff and build QOC capacity in the project.

The Evaluation Team also noted that contracting was new to Concern Worldwide Bangladesh, and they did not have enough HR time, experience and/or person power to do it themselves. In the JSI case, the terms of reference for the work to be carried out and the deliverables to be produced were not described in sufficient detail. When Concern Worldwide Bangladesh felt it was not getting the support it needed, they were unable to go back to the contract and refer to what they wanted and needed. They were also unable to make the contractor deal with a personnel issue. In other words, they did not manage the contract effectively. No one at Concern Worldwide Bangladesh has had training in contract management, and at present there is no cell that can assist CSP and other projects when they require contracting expertise.

Recommendation #21: *Contract management training for Concern Worldwide Bangladesh/CSP staff would be useful. It is also possible that joint implementation and learning is another way to build Concern Worldwide Bangladesh's expertise in contract management.*

C. Supervision of Program Staff

The field staff expressed satisfaction with the supervision they have received from Concern Worldwide US that has given them advise on technical issues and identified quality technical assistance on a number of diverse topics that strengthened the program. Supervision from Concern Worldwide Bangladesh office in Dhaka has been reduced since the CSP Senior Project Manager post has been vacant for some four months when the previous manager was promoted to Assistant Country Director. In fact, he was the

second CSP Senior Project Manager who has been promoted to an Assistant Country Director. The recently promoted manager continues to provide some support to the CSP because he has a personal interest and ownership in the project that he was intimately involved with for a number of years. In many ways he was the person who conceptualized the community-based, capacity-building project and saw the need to link the community, municipality and health services in a partnership.

The CSP implementation personnel operate as a team; teamwork is highly valued. There seems to be little internal friction and everyone appears to be working for the common objectives without undue thought or concern for their individual advancement or recognition. They are dedicated to the project and what it is trying to achieve and put that above personal considerations. This spirit has been transferred to the partners at the municipal and ward levels. Supervision is supportive, always helping the staff to improve their performance. Without exception the staff works hard and long, often late into the night and on weekends, indicating a high degree of loyalty, dedication and commitment.

D. Human Resources and Staff Management

Concern Worldwide Bangladesh has a personnel manual that spells out all the benefits and personnel policy for the agency. The various field positions, from CSP Coordinator to Field Trainers to Research Assistants, have specific job descriptions. These are used as part of the staff member's annual performance review. The process is well developed and consists of the employee doing an oral self-assessment with the person's supervisor, the results of which are written once agreement has been reached. Part of the review process is a discussion of expectations for self-development and activities during the forthcoming year. Staff members have a generally favorable attitude toward the performance review process and think it helps them become better professionals. There was some concern expressed that while the staff speak positively of the training they have received, some individual, career-advancing training plans and courses have not been fulfilled. This is usually because of program obligations and responsibilities preclude the person's participation. There is just too much going on for all training that is wanted or has been planned to be realized.

Staff annual salary increments are linked to their annual performance review and depend on the grade the person is given. Cost of Living Allowance (COLA) increases are the same for everyone. There were no complaints about Concern Worldwide Bangladesh salaries although they are known to be lower than some other international NGOs. Concern Worldwide Bangladesh salary scales are reviewed every three years and adjusted accordingly. The low staff turnover rate (despite the remoteness of the project site) is an indication that Concern Worldwide Bangladesh employees get a high level of job satisfaction from their work. Morale is high among the CSP staff.

The CSP personnel are very pleased that Concern Worldwide Bangladesh was awarded the cost extension that means that they should be keeping their jobs. Concern Worldwide Bangladesh has not promised anyone a job in the new project that will be launched in

October, but they have said that they will need to add significantly to the staff to cover the very large increase in target population and that anyone having experience in Phase One of the CSP will have an advantage. Everyone currently in CSP appears optimistic and is eager to be a part of the extension phase.

Challenges and Constraints – Two issues were raised that Concern Worldwide Bangladesh management should give some attention. One has to do with low per diem rates when the staff travels to Dhaka. The amount is only sufficient for minimal housing and could put staff members in less secure locations and facilities. Per diem rates should be reviewed and compared to what other International NGOs compensate their national staff when they visit Dhaka on business.

The second issue concerns vacation time. Most of the staff members took about three-quarters of the vacation due them each year (entitlement is 20 working days). Any unused leave is lost at the end of the calendar year. The staff think that if project activities and demands prevent them from taking all their leave, they should be able to carry forward what they have not utilized (up to a limit of one year of unused year). Or the alternative that appeals to some employees was payment for the unused leave. The HR policies of other international NGOs should be checked to see what their practice is and due consideration should be given to devising a system that Concern Worldwide Bangladesh employees feel is fair.

E. Financial Management

Concern Worldwide US's and Bangladesh's financial management of project expenses and budget were found to be in order. Field personnel said that they received timely budget analysis, including burn rates that let them know how they were doing spending the project budget against original projections. The major problem that Concern Worldwide US and Bangladesh has had in the Child Survival and Health Grant was consistently under-spending the budget. Concern Worldwide is a very frugal organization and pinches pennies wherever and whenever possible. Moreover, they have done their utmost to avoid unsustainable inputs, approaches and practices. The slow rate of spending was pointed out in the Midterm Evaluation. Concern Worldwide US in September 2002 requested a no-cost extension from USAID, but it was rejected.

Spending picked up during the second half of the project, but Concern Worldwide US/Bangladesh was still left with a large unspent amount with a half-year to go in the life of the project. The cost of the final evaluation and additional technical assistance (e.g., follow-up study of the private practitioners) will add to the costs in the final quarter. In addition, Concern Worldwide US requested and was granted permission by USAID to purchase a van that will be very useful, actually essential, in the cost-extension project when there will be a large number of personnel to transport from site to site. It would also reduce the heavy car hire line item that would have been required. Having seven sites, and a number of them being several hours away from one another will result in high demand on Concern Worldwide Bangladesh for transport, in sharp contrast to the Saidpur and Parbatipur site where the two municipalities were less than 30 minutes apart.

Moreover, remaining funds will be used for long-planned exchange visits to urban health projects in Nepal, India and Rwanda as well as investments in hand-held computers that CHVs will introduce in the new municipalities as part of the HMIS.

F. Logistics

The Midterm Evaluation mentioned some problems with delays in procuring and shipping equipment and supplies. During the Final Evaluation it was brought up that the procurement of computers was delayed for over 10 months by Concern Worldwide Headquarters in Dublin. This was finally straightened out and there has been no repeat of this problem.

Considering that the CSP field office in Saidpur has no access to the Internet, the project was managed well. Concern Worldwide US office in New York was only able to communicate with the Saidpur office via Concern Worldwide Bangladesh's Rangpur Regional Office. Communications will improve dramatically when the CSP office moves to Rangpur with the initiation of the cost extension project in October.

Because the CSP provided no hardware to the municipalities or anyone else in the project, procurement and logistics played a minor role. It should be noted, however, that the CSP did purchase IEC materials (posters), HMIS books and diaries, and a few computers for the two municipalities.

G. Information Management

With technical assistance from ICDDR,B, the CSP developed and put into use an HMIS that seems to have been well received after its recent introduction. This will provide all levels of the project, from the ward to the municipality to CSP mangers, with the key data that they require to monitor project progress. Decision-makers will now have the data they require to make informed management choices. The major issue in the future of the HMIS is whether the MND staff will maintain the system so that it continues to produce accurate and timely information.

The CSP has developed considerable local expertise in survey methodology and techniques. For example, the staff has been trained and involved in capacity-building monitoring at both the ward and municipality levels. They have also become experienced in the LQAS survey methodology that has broad application. In addition, the local partners, especially the municipal staff members, have capability in the same techniques that will be useful for them and the municipality in the future when Concern Worldwide Bangladesh is no longer available locally.

Concern Worldwide Bangladesh's Research Officer and Research Assistants in the field provide a valuable resource for the Concern Worldwide organization in Bangladesh. They should be involved in establishing a means to report on referrals based on the referral slips that will be introduced. This information will provide valuable feedback on who is referring when, for what causes, and to whom. The project will understand much

better the dynamics of the municipal health structure and the network of informal service providers and referral mechanisms (e.g., PPs/RMPs, CHVs, TTBAs, Imams). This will also give information on referral compliance – are those referred to various health facilities actually showing up on a timely basis; if not, why not?

Challenges and Constraints – As mentioned in the findings of the final evaluation and recommendations, the CSP needs to strengthen its maternal/infant/child death reporting system. Guidelines are required that spell out exactly how it is to be done. A medical person should be involved in the determining the clinical cause of death. The social cause is just as important since it tells us where the system broke down and needs to be addressed.

Recommendation #22: *Now that the HMIS has been designed and introduced to the WHCs, there is a need to give the community's ownership. HMIS guidelines should be developed with special emphasis on tracking the clinical and social causes of maternal/infant/child deaths. These data should be provided to the MESPCCs and rolled up ands analyzed at the municipal level on a regular (monthly?) basis.*

H. Technical and Administrative Support

Since assuming responsibility for the CSP just before the Midterm Evaluation, the Child Survival and Health Adviser, Michele Kouletio, has provided strong and innovative leadership to the CSP. The project has benefited from unusually insightful and creative leadership, from Breda Gahan to Drs. Shahnewaz and Musha, who designed the original project and oversaw its launch and difficult early years. Michell Kouletio, with a strong field background in Child Survival project implementation, gave Concern Worldwide US the expertise and familiarity with USAID rules and regulations that it needed as an inexperienced USAID grantee. She has networked Concern Worldwide US with the leaders in Child Survival programming in CORE and CSTS+, taking maximum advantage of all the resources that are available. The result is that, even though the CSP is Concern Worldwide US's first USAID Child Survival and Health Grant, they are very well positioned and have made contributions with their innovative community-based, capacity-building project in Saidpur and Parbatipur. They are also contributing to important areas of Child Survival programming in the US as well as in Bangladesh. The work that Concern Worldwide US is doing with CSTS+ on capacity-building and sustainability monitoring are on the cutting-edge of process monitoring and evaluation. In fact, the Bangladesh experience is contributing to Concern Worldwide US's program in Rwanda in terms of community mobilization, working with local administration, maternal and newborn care and capacity assessments. And Concern Worldwide Bangladesh's work involving the private practitioners is also innovative and leading the way in the country. Certainly Concern Worldwide Bangladesh's strategy underlying the CSP, focusing entirely on capacity building rather than service delivery and having no hardware inputs, is unique and providing a new approach for others in Bangladesh and elsewhere in the CS network to consider and follow. It is hoped and expected that Concern Worldwide Bangladesh and the CSP can play the same role in finding a way to effectively engage the ultra poor (lowest 10-20%) and ensure that they benefit from the ward-level health system just like the rest of the community.

V. Conclusions, Lessons Learned and Key Recommendations

A. Conclusion

The Final Evaluation Team was uniformly impressed by the health status and process results that the CSP has achieved over the life of the project. There are those who will question the findings saying that the Rajshahi Division is an easier place to work[6], that the project sites were small, that in a few years the WHCs and municipal coordinating bodies will no longer exist or will be ineffective. Based on previous experience, it is easy to understand why they say this. WHCs have been formed before and are either no longer in existence or active only during NIDs. What has been done in the CSP is very hard to grasp for someone who does not have experience in community or organization mobilization and capacity building. This is especially true when health experts (professionals who are most comfortable when dealing with service delivery issues) are involved. Certainly, service delivery is an essential component of the CSP model; but it is only one of the three vital components, all of which must be strengthened and work effectively in partnership if results are to be achieved and sustained.

It is difficult to adequately describe what has been accomplished in Saidpur and Parbatipur. Yes, the figures from the baseline and final KPCs are there which show excellent improvement in the key indicators. And, yes, the numbers showing improvement in the capacities of the municipal and ward committees also demonstrate that something positive is happening. But numbers are not a good way of demonstrating the confidence, empowerment and ownership of the target population, those living in the wards that have been involved in and benefited from the CSP activities. How does one describe the energy and dedication of the CHVs, young women like Ratna in Parbatipur, who at the age of 20 has served as a CHV for several years and has recently been hired by the municipality as a health worker? How does one put into words the commitment of municipal health workers in Saidpur who have worked, and worked hard, for 17 months without receiving any salary? Concern Worldwide Bangladesh and the CSP partners have developed an urban community-based health system that is effective and appears to be sustainable. This chapter will focus on the lessons learned about the CSP by the Final Evaluation Team followed by a limited number of key recommendations for CSP to address as they move onto the awesome task of introducing and implementing the model to seven district municipalities having a total population of over 800,000 in the Rajshahi Division.

B. Lessons Learned

The lessons learned refer to what the evaluators, Concern Worldwide Bangladesh/US and all the CSP partners and stakeholders, at both the municipality and ward levels, take away

[6] In fact, the Rajshahi Division is one of the poorest regions in Bangladesh with among the worst human development indicators and a heterogeneous population base with mixed ethnic groups.

from the Saidpur and Parbatipur experience and how it can/will be applied in the expansion phase that will be launched soon. Eight lessons have been identified:

1) *Do it First:* *with up-front investment in urban/community based structure, municipalities can achieve priority health outcomes and impacts more effectively and sustainably (than starting with vertical or hardware-heavy health interventions).*

The municipal and community capacity building and mobilization is not something that can be tacked on to an urban health program. It has to be an integral part of an urban health strategy. More specifically it has to be the first step, the foundation on which the urban health program is built. Large urban population can frighten a program planner. Where to start? If the wards and municipal authorities, the commissioners and chairmen, are oriented and convinced first and agree to support the building of capacity in the health services, at the municipal level and in the wards, then the opportunity is there to realize impressive health results in a relatively short time. Building capacities and making the MESPCC effective, the formation and operationalization of the WHCs, the selection and training of all the community volunteers (i.e., CHVs, TBAs, PPs, Imams, teachers) – these are the crucial steps in building those blocks that will make up the strong foundation upon which an effective and sustainable urban health program can be developed.

A frequently seen approach to urban health care consists of providing a large amount of hardware to the involved municipalities. This often consists of the construction of clinics or health facilities, the provision of equipment (e.g., ambulances, x-ray machines), the supply of medicines, the payment of salaries. There may be a process/capacity-building component included, but it is usually restricted to the training of health providers and only in technical or clinical aspects. The latter may or may not be done since it is the hardware that everyone is interested in and focuses their attention on. Even if included in the project plans, the community aspect is typically neglected or forgotten about altogether.

If the WHCs and the MESPCC are formed first and satisfactory performance in the software activities is made a **prerequisite** for the hardware investments, things might/could be different. With the municipal health structure in place and functioning, it would be possible to develop a meaningful health program, effectively utilizing any outside assistance that might come its way. If there were to be clinics built, the MESPCC could determine the best location based upon input from the partners – i.e., where maximum numbers would have optimal access. A community-based needs assessment, with all the local partners, would help determine what services and equipment would be most important to them and the target population. Such a strategy calls for flexible planning, allocating resources on an amount-per-municipality basis (possibly based on so much per capita) rather than determining an arbitrary package of inputs that each urban area will receive prior to the start of the program. The CSP approach will produce results as described in this evaluation finding if the program managers are results-oriented, sensitivity to the community and its needs, and committed to improving health impact that is sustainable.

2) *Catalyst:* *A catalyst (e.g. IO, GO, NGO) can partner with municipal authorities to build capacities to operate and manage quality, lasting health services.*

Concern Worldwide Bangladesh has served the role of a catalyst in Saidpur and Parbatipur. They raised the awareness of the authorities, mobilized and organized them according to pre-existing ordinances and then built their capacities using the AI methodology. Their approach maximized ownership and group accountability. The municipalities have now involved all the local health resources, those people who already existed in the community but were not linked or coordinated for the common good. Concern Worldwide Bangladesh's inputs in this program were limited to catalyzing and capacity building. It did not require a large amount of resources; rather, it required considerable expertise (in AI and capacity building) and time. While in the first few years of the CSP, Concern Worldwide Bangladesh and the project partners were developing the approach, curricula and materials and learning what worked and what did not, the building of effective, functioning organizations at the municipal and ward levels did not take an inordinate amount of time. Now that a lot of this has been done and course curricula and materials are available, it is possible to envision the process being achieved in a couple of years.

The question on everyone's mind is can the Saidpur and Parbatipur model be **replicated in larger municipalities** and can it be sustained. On the first issue, CSP approach will be introduced into larger municipalities in the same region of northwestern Bangladesh. The catalyst will have to streamline and modify their approach to fit the demands on municipal authorities' time (especially the chairmen) and a faster pace of life. For example, will the CHVs be less effective since the program in larger cities will have greater competition for the student's time? But there is no reason that the model cannot be effective. The basic building blocks are the same – the WHCs. And the municipal coordinating body is the same – the MESPCC. The municipal health staff may be larger, but it is basically the same. Political pressures are expected to be greater, but will they be insurmountable? So there is optimism that Concern Worldwide Bangladesh can play the catalytic role effectively in the new municipalities just as it did in Saidpur and Parbatipur.

Can it be **sustained** once Concern Worldwide Bangladesh, the catalyst, leaves and is no longer present on a regular basis? The expectation is that once the ward and municipality health structure has been formed and reach the mature level of capacity, Concern Worldwide Bangladesh or the primary outside catalyst is no longer required. It is similar to the relationship between parents and children. The former provides for their child's formal and informal education until they exhibit the maturity to live and survive on their own. Of course, the parents continue to be there and are available to provide support when called upon to do so, but basically the children operate independently. It is not considered good parenting to create dependency so that children continue to live with their parents and rely upon them for economic support. Similarly, it is not good programming if a municipality is forever dependent on the catalyst to provide support for their health activities. However, to provide support in the future if and when a

municipality needs an outside perspective or arbiter, it is thought to be advisable for Concern Worldwide Bangladesh and the CSP in the expansion phase to include a local NGO already established in the municipality as a long-term catalyst or support agent. This local catalyst would be able to assist in the development of the municipal and ward capacities, learning the CSP methodology/techniques and tools in the process. Thus, when it is time for Concern Worldwide Bangladesh to move on, the local group remains, is totally integrated into the municipal health operation (e.g., a member of the MESPCC) and is there to provide a helping hand if and when needed (e.g., when a new municipal chairman is elected and requires orientation or if a disagreement arises in the MESPCC and needs an objective arbiter).

3) Supervision and Accountability: *Supervision and accountability can be developed at community and municipality level to reinforce a local health system.*

Supervision and accountability are two aspects that are critical links in health programs but are all too often missing. TTBAs are good examples. A significant percentage of the rural TBAs have been trained over the last several decades. Unfortunately after training, they received little or no supervision or refresher training. They were left to their devices and in recent years, research has shown that they have had little or no impact on reducing maternal mortality. As a result, the international health community is now discouraging their participation. In fact, it is not the TBAs that failed the system; it was the system that failed the TBAs. The CSP demonstrated that TTBAs that are made part of the system and linked with/supervised by the existing health structure can be very effective and serve as reliable motivators and referral agents. In addition, the support of the WHCs will continue to sustain the TTBAs.

The CSP urban health model also provides accountability that is typically missing from health programs. As was described in the report, there is no health structure in the municipalities which means there is no accountability. As mentioned, the MOLGRD has no one who is responsible for health even though they are supposed to oversee and support health care in municipalities. The Ministry was not represented at either the pre- or post-evaluation workshops. They are unable to provide any accountability for above. However, when the MESPCC and WHCs exist and are trained and capable, they can and do provide the accountability that is otherwise missing. So in place of the missing accountability from above, there is **accountability from below**, from the community and the health committees. This form of accountability is closer and much more immediate, hence more effective.

4) Limited Central Support: *Despite limited support from central government, effective health program is possible if all relevant health resources are coordinated by the municipality authority as mandated.*

While the WHCs and MESPCC, successor to the MCHC, were mandated almost 10 years ago by the MOLGRD, they rarely exist and even more rarely are effective in carrying out their roles and responsibilities. The WHCs that can be found today are primarily convened and active no more than twice a year in support of the NIDs. The CSP

experience has demonstrated that these groups can be highly effective in mobilizing and building the capacities of existing local resources. Separately the TBAs, the teachers, the Imams, the PPs are not effective, especially before they have received an orientation and training. But connect them to one another through a WHC and add a cadre of energetic young volunteers who visit each household in their neighborhood several times a month and the results are impressive. And what is most encouraging is that the costs are very low. Concern Worldwide Bangladesh covered the cost of developing the curricula and materials and the training, and there are few costs beyond that. This model is not dependent upon expensive inputs that would place an economic burden on the municipality and/or community to maintain. The recurrent costs involved in sustaining the CSP urban health model is practically nothing, amounting to little more than a monthly meeting (for which the Saidpur Municipal Chairman has recently appropriated Taka 100/month for each WHC and CHV meeting) and voluntary contributions made in support of the poor in their ward.

5) Municipal Leaders: *Enlightened and empowered municipal leaders (i.e. civil society) can effectively and swiftly mobilize and organize local human and financial resources to establish an enduring health system.*

The CSP urban health model is one of the best examples of what can be achieved when improved civil society meets a strengthened health sector. The approach can turn doubting or hesitant leaders into supporters by demonstrating to them the commitment and capability of the WHCs. This was the case with the new Municipal Chairman in Saidpur who was initially skeptical of the program and had an intention of not supporting the activity. However, orientation and observation of how the structure functions convinced him of its value. As a convert, he demonstrated his support by instituting monthly payments to each ward to cover the cost of monthly program meetings and renew the payment of the municipal health staff who had been without pay for so long.

The municipal and ward authorities are beginning to appreciate that their involvement on behalf of the constituents' health can possibly pay positive political dividends. It just may be possible for them to do well by doing good. Once the commissioners and chairmen appreciate this, their support for the CSP urban health model will be assured with little or no need for outside encouragement. If this is the case, then the CSP approach can be a means of making the political system work in favor of the community.

6) Least Advantaged Group: *Less advantaged community members can access life-saving emergency health services through the negotiation, fundraising, and social support of local leaders/health committees, however the Least Advantaged Groups (LAGs) have been left behind.*

As described above, the WHCs and the urban health model has assisted the poorer members of the community. Case studies told of poor households who were assisted by their WHCs and their community. However, as almost all other development programs have experienced, the CSP has had less success in reaching the poorest of the poor, maybe the lowest 10% of the population. To extend the safety net that has been

established to include the "ekdam" poor, more effort is required. First, there's a need for a good definition of who the LAGs are; this will probably include the number of times they eat or have a hot meal a day. It almost certainly would include women-headed households. By focusing on this very poor segment of the population and developing ways to integrate them into the program, the CSP could make a real contribution to the broader development field that to date has not come up with any effective strategy.

7) Volunteers: *Young volunteers are effective and dropout is not an issue when there is a community support system.*

Like the TTBAs in the CSP municipal health program, the CHVs have proven wrong international theories on what works and does not work. With a high level of community enthusiasm and involvement, students, both females and males, are eager to work as volunteers and devote up to eight hours a week helping their neighbors on maternal and child health issues. The fact that there are additional youth who work along side and assist the CHVs is even more remarkable. These "interns" are the CHVs-in-waiting who will step into the CHV's slot if the CHV gets a paying job, gets married or moves with her family to another location. With all the news these days about the apathetic and misguided youth who are attracted to and use drugs, the CHVs are a positive example of how youth can contribute and how best to utilize their skills, energy and commitment.

8) Urban Health Strategy: *An urban health strategy is needed to ensure available resources to address this public health problem.*

Bangladesh needs an urban health strategy based on the experience of the CSP in Saidpur and Parbatipur municipalities. The 284 municipalities deserve and require some attention to their health situation. This is true today and will become ever more urgent as the urban population of Bangladesh burgeons in the years ahead.

In a climate of limited resources, the government should promote the use of existing resources in the community, harnessing, coordinating and directing their energies and efforts. It would be helpful if the MOLGRD were to lead this policy development, but this may be problematic without any person at the Ministry directly responsible for health matters.

C. Key Recommendations

Based on the findings of the Final Evaluation, the Evaluation Team has identified a limited number of key recommendations that Concern Worldwide US and Bangladesh and the CSP should consider as they expand the model to seven additional municipalities. The key recommendations are divided into two categories, those referring to the existing program (referred to as the "retrospective" recommendations) and those that apply to the forthcoming phase (the so-called "prospective" recommendations).

1) Retrospective Key Recommendations: While the CSP has generated some excellent results, there are several things that can be done to strengthen the program. Some of

these suggestions have already been identified by CSP managers and partners, but the Evaluation Team thought it worthwhile to include them with the key recommendations to refine the Saidpur and Parbatipur model that will be implemented in the seven new municipalities. They are:

♦ Continue to develop the **QoC/QI**, TTBA (exploring the integration with SBAs and introduction of maternal health and birth preparedness cards) and PP/RMP (including the addition of homeopaths) components and introduce a referral tracking system;

_ Refine **technical strategies** (ARI/pneumonia, diarrheal disease control, nutrition, maternal and newborn care) based upon findings of KPC-2004 and clinical/social verbal autopsies reducing the morbidity and mortality that continues to exist in the community;

♦ Improve/develop guidelines for ward-level **annual planning** and consolidate WHC/MESPCC capacity-building assessment tools;

♦ Launch special effort to identify and reach the **LAGs**; and

♦ **Monitor sustainability** through process documentation.

2) <u>Prospective Key Recommendations</u>: As the CSP matures and becomes a municipal health model, there will be a host of new challenges. Concern Worldwide Bangladesh's plan of hiring an Advocacy Officer to devote full-time to documenting and disseminating information of the activities in northern Bangladesh and attempting to integrate what has been learned into national policy is to be encouraged. Working closely with USAID and others in Dhaka that are committed to improving urban health in Bangladesh, Concern Worldwide Bangladesh should make every effort to influence the way the MOLGRD and donors go about developing the health sector in the cities and municipalities, ensuring that investments are used as cost-effectively as possible. Because an opportunity to witness for oneself has been found more effective than either the written or spoken word, every effort should be made to get decision-makers to visit the Saidpur/Parbatipur Learning Center. Other recommendations to facilitate the wider adoption of the municipal health model as developed under the CSP include:

_ Develop a Municipal Health Program (MHP) **Operations Manual** that would contain all guidelines and training curricula/materials on all aspects of the program;

_ Engage an economist to carry out a **study of the costs** associated with launching ward and municipal health committees and networks as well as strengthening the municipal health staff; and

_ Select a local NGO (most likely a part of the NSDP) to serve as a **catalyst** to assist each municipality to sustain the effort after the initial capacity-building efforts have been completed.