CONCERN WORLDWIDE

Child Survival & Health Grants Program
Cost Extension Grant
Cooperative Agreement FAO-A-00-00-00039-00

Municipal Health Partnership Program (MHPP)

October 2004 – September 2009

Building on Saidpur & Parbatipur Experience
For urban health in Rajshahi Division, Bangladesh

SECOND ANNUAL REPORT

October 1, 2005 - September 30, 2006

SUBMITTED ON October 31, 2006 TO USAID/GH/HIDN

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ACRONYMS

ACPR	Association for Community and Population Research
AMDD	Averting Maternal Deaths and Disabilities (a JHPIEGO project)
ANC	Antenatal Care
ARI	Acute Respiratory Infection
AIDS	Acquired Immuno-deficiency Syndrome
BCC	Behavior Change Communication
CDD	Control of Diarrheal Disease
CHV	Community Health Volunteer
CS	Civil Surgeon
CSHGP	Child Survival & Health Grants Program
CSP	Child Survival Program
CSTS	Child Survival Technical Support
C-IMCI	Community Based IMCI
DD-FP	Deputy Director- Family Planning
DIP	Detailed Implementation Plan
EmOC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
EOC	Emergency Obstetric Care
FP	Family Planning
FWV	Family Welfare Visitors (based at MCWC with some outreach to communities)
GoB	Government of Bangladesh
HFA	Health Facility Assessment
HICAP	Health Institution Capacity Assessment Process
HMIS	Health Management Information System
IAP	Indoor Air Pollution
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
IMBCT	Inter-Municipal Behavior Change Team
IMCI	Integrated Management of Childhood Illnesses
KPC	Knowledge, Practice and Coverage Survey
LAMB	Lutheran Aid to Medicine in Bangladesh
LC	Learning Center
LCCC	Learning Center Coordination Committee
LOD	Learning and Organizational Development
LQAS	Lot Quality Assurance Sampling
MCWC	Maternal and Child Welfare Center
MESPCC	Municipal Essential Services Package Coordination Committee
MHMIS	Municipal Health Management and Information System
MHS	Municipality Health Staff
MHPP	Municipal Health Partnership Program
MMO	Municipal Medical Officer
MNC	Maternal and Newborn Care
MOHFW	Ministry of Health and Family Welfare
MOLGRD&C	Ministry of Local Government, Rural Development & Cooperatives
MOET	Management of Obstetrical Emergencies and Trauma
MOU	Memorandum of Understanding
NGO	Non-Government Organization

NSDP	NGO Service Delivery Program, USAID
NID	National Immunization Days
PAC	Project Advisory Committee
PMDA	Prenatal and Maternal Death Audit
PP	Private Practitioners
PRA	Participatory Rural Appraisal
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VERC	Village Education and Resource Center
WHC	Ward Health Committee
WHO	World Health Organization

INTRODUCTION

The Municipal Health Partnership Program (MHPP) is a five year (October 2004-September 2009) cost extension project of Concern Worldwide in Bangladesh with the support of USAID Child Survival Health Grant Program (CSHGP). This is an urban health scale-up of a promisingly sustainable model for health in partnership with the original working areas of Saidpur and Parbatipur municipalities under the predecessor program (2000-2004). Through the development of this model for maternal, newborn and child health, the original program was declared to have "succeeded in its objectives of building capacities, developing effective health committees at both the municipal and community levels, and achieving impressive outcomes in terms of better knowledge and practices".

The MHPP program's goal is to reduce maternal and child mortality in Bogra, Dinajpur, Gaibandha, Joypurhat, Kurigram, Nilphamari and Rangpur municipalities in Rajshahi Division, Bangladesh, reaching 225,000 women of reproductive age and 94,000 children under-five. Interventions are focused around the primary burdens of mortality being maternal and newborn care, acute respiratory infections, diarrhea and malnutrition.

The four key strategies guiding the overall program approach include the following:

1) Foster learning and networking across and within municipalities,
2) Strengthen partnerships and technical capacity between the Municipal Health Departments and private, government and NGO service providers.
3) Build the management capacity of the Municipal Authorities
4) Support community led health promotion campaigns emphasizing male involvement, participation, and social support for income poor households.

The original sites from the predecessor project of Saidpur and Parbatipur municipalities are serving as Learning Centers through which the program can promote quality health services, a more favorable urban health policy, and accelerated scale up of the model for municipal health partnerships throughout Bangladesh. This report describes progress towards objectives, key achievements, and constraints for the second year and plans for the third year.

A. MAJOR ACCOMPLISHMENTS OF THE PROGRAM

The MHPP program has made great strides towards its objectives in the program's second year. The following is a description of the most significant achievements of this reporting year, followed by a brief description of the main accomplishments under each objective and a table of activities by objectives.

a) Most Significant Accomplishments

1. Reactivation and Development of Municipal Essential Services Package Committees (MESPC) into multisectoral platforms addressing gaps in the health system

Reactivation of MESPCCs in ALL 7 municipalities
Transformation of the MESPCC to a multisectoral platform.

100% of MESPCC meetings held

The MESPCC, a coordination committee bringing together key actors in ensuring the health of the population, is at the heart of the program's health systems strengthening efforts. The MESPCC in each municipality is headed by the Municipal Chairman (highest elected position of the municipality) and was initially to include the District Civil Surgeon, the Deputy of the Directorate of Family Planning, representatives of NGOs providing health services, and senior municipal health staff (MHS). In their efforts to reactivate the MESPCC, which existed in paper only, the MHPP team has successfully advocated for and involved leaders of related government sectors including the Ministry of Education, Islamic Foundation, Social Welfare and Women's Affairs; and all Commissioners (elected leader of each ward within the municipality).

Importance:

Through the MESPCC government agencies and other actors are for the first time coordinating their efforts in addressing the health of the municipal population. Regular meetings are resulting in increased accountability of actors involved, especially government entities, to health issues and to the community directly through the involvement of Commissioners. Only in their first year of existence, already there are several examples demonstrating the MESPCCs' developing capacity resulting in actions addressing gaps in the health system.

See *Section O: Results Highlights* for details on the accomplishments of MESPCCs thus far demonstrating the forum's potential as a Promising Practice.

Contributing Factors:

Bringing together the members of the MESPCC required months of networking and meetings with key individuals and careful articulation of the purpose and benefits of such a forum to politically sensitive listeners. The MHPP Project Managers of each municipality and the program's senior managers were able to accomplish this feat through their hard work and incredible networking and communication talent. Also key to the success of the MESPCCs are well organized, purposeful meetings, especially in this early stage, as how members value the MESPCC and their commitment to it is being shaped. MHPP staff are still providing significant support to Municipal Chairmen and MHS staff in the preparation of the agenda and other meeting logistics, however some municipalities (Kurigram and Joypurhat) are beginning to take the lead in MESPCC meeting preparations. Project Managers are continuously working to build the Municipal Authority's ability to take ownership.

2. Building a strong relationship with the Directorate General of Health (MoHFW), Directorate General of Family Planning (MoLGRD&C), and MCWC doctors.

Official order from both Directorate General of Health (MoHFW) and Directorate General of Family Planning (MoLGRD&C) for MCWCs to serve as Centers of Excellence.

Demonstrated commitment to the program from MCWC doctors through participation at WHC and other health related meetings/events.

Training of ALL Maternal and Child Welfare Center (MCWC) doctors and Family Welfare Visitors (FWVs) in preparation for the training of CBAs.

See *Section O: Results Highlights* for further details on Centers of Excellence and the role of the Directorate Generals and MCWC doctors.

Importance:

The active support of the Directorate Generals (DG) of Health, DG of Family Planning and MCWC doctors is a critical factor for the success of the MCWC as Centers of Excellence. The MCWCs serving as the site of CBA training is the key to building a strong relationship between CBAs and the clinics, resulting in greater numbers of deliveries at the clinics and thus mother and newborn lives saved. The strong commitment of the DGs and the MCWC doctors to the project is a major achievement for two reasons. One, it serves to solidify the clinics' (and health system's) connection to the community and two, the DGs and MCWC doctors will be important allies not only for MNC related initiatives but for MHPP's overall advocacy efforts addressing gaps in the health system.

Contributing Factors:

Much effort was put in by the MHPP team to gain the Directorate Generals' offices support by sensitizing key personnel regarding the CoE initiative, involving them in the initial Health Facility Assessment to select the sites to serve as CoEs, the revision of the CBA curriculum, an other related matters. The official order from the both DG offices for the MCWC teams to serve as a Center of Excellence significantly reduced reluctance of MCWC doctors to engage with the program. These initiatives were facilitated through the MESPCC, which proved to be an effective forum in this matter.

3. Formation and increased capacity of Ward Health Committees (WHCs)

100% of WHCs formed (75 in total) by June 2006 (64 formed 1st year)
65% of WHCs meetings held with an average of 70% of members in attendance
81% of WHCs received 2-day orientation/training
78% of WHCs have well written plans
100% of WHCs successfully observed FOUR special days (World Health Day, World Breast Feeding Week, Safe Motherhood Day, World AIDS Day) by organizing special events

The WHCs are representative bodies of 15-20 volunteer community members, headed by the elected Commissioner of the ward, including teachers, businessmen, CBAs, CHVs, Imams, representatives of least advantaged groups and one representative of the Municipal Health Department (MHD). The WHCs are the communitys' connection to the health system. They are responsible for creating awareness and promoting proper health and hygiene practices, raising funds for emergency healthcare situations, negotiating special rates at clinics and hospitals for community members, and supporting CBAs and CHVs.

Many of the earlier formed WHCs are already showing significant progress and increase in capacity, as evidenced by:

- WHCs are creating action plans through a participatory process including details such as when, how and whom for each activity. WHCs also review their annual plans every quarter to assess progress.
- WHCs are increasingly becoming a trusted resource for community members in need, with numerous examples of rapid coordinated action resulting in saved lives. (See ANNEX A: Case Studies for examples)
- WHCs are proving their reach into the community by securing high levels of community participation at events for special observance days.
- WHCs are creating much needed awareness in the community of the array of government and non-government resources (special government programs, etc.) available to them by inviting guest speakers from various Government bodies and non-government bodies to meetings.

Importance:

Well functioning, recognized and trusted WHCs, along with the network of CHVs and CBAs they support, are the bridge between the community and healthcare facilities. WHCs give community members a voice by negotiating prices with clinics and hospitals, and holding healthcare facilities and the health system accountable (i.e. through participation of the Commissioner in Cabinet meetings and MESPCC, etc.). They are effectively creating awareness among community members.

Contributing Factors:

The WHC requires significant commitment from its members who donate their time not only for official WHC meetings and events but also to make themselves available to individual community members (hear their concerns) and communicate with the group they represent (i.e. TBA representative communicates with other TBAs). WHC members are a diverse group, from those who are not literate to those with graduate degrees. To bring together such a dedicated group of individuals in ward after ward, and ensure their capacity to run an effective body is no easy feat. Commissioners are busy and some were not eager to take on the responsibility of a WHC (or do so in name only). Continuous discussion with Ward Commissioners by MHPP Project Managers and successful examples set by WHCs from the original CSP in Saidpur and Parbatipur were important factors in accomplishing this feat.

Many WHCs are receiving substantial support in the planning, coordination and development of relationships with important community resources (other WHCs, NGOs, Gov. Agencies, clinics, etc.), from MHPP Project Managers who serve as a member on the WHC. Continuous capacity building efforts are showing much promise in gradually eliminating this dependency (see *Section F: Sustainability Measures* for further details).

4. Concern conducting national pilot C-IMCI roll-out in nine municipalities (urban) and one upazilla (rural).

- Successful advocacy by MHPP to include Rural Medical Practitioners (RMPs – 6 months medical training, no medical degree) in C-IMCI trainings.

- Concern Private Practitioners (PP) C-IMCI module and facilitator's guide to be adopted nationwide for training PPs (including RMPs) upon final approval.
- Agreement with MoH to develop training module on C-IMCI related behavior change messages for CHVs and Imams for nationwide adoption.
- Homeopath physicians (included in MHPP's C-IMCI efforts in Kurigram and Nilphamari municipalities due to high utilization, though not recognized by the government) agree to adopt standard protocols for treatment of children under five.

Concern is part of the IMCI National Working Team (NWT) of the Ministry of Health and Family Welfare (MoHFW). The NWT includes MoHFW officials in charge of the national IMCI and C-IMCI roll out, representatives of UNICEF, WHO, NSDP and NGOs involved in piloting the program.

Status of National IMCI/C-IMCI Roll Out:

Facility based IMCI roll out under way: 80 upazillas covered, all 472 covered by 2010
C-IMCI in pilot phase: 9 municipalities (Concern), 6 upazillas (1 concern, 5 other NGOs)
Status: 1 municipality covered (Dinajpur served as pilot), remaining (including other NGO areas) begin October 2006.

Importance:

Concern's position on the NWT, being awarded the task of developing the official Government supported Private Practitioner's C-IMCI module for the country, and winning the advocacy effort of including RMPs in the national C-IMCI roll out are important developments, giving Concern visibility at the national level and helping pave the way for further national advocacy efforts. RMPs are the first choice of healthcare for a significant portion of the population in many areas of the country. Leaving this cadre out of the national roll-out of C-IMCI would have drastically reduced the success of the campaign.

Contributing Factors:

Senior Concern staff were paying close attention to developments regarding IMCI in the country from the very beginning and were able to position Concern well through contacts and important contributions at initial information gathering meetings called by the MoHFW, so that once the NWT was formed Concern was given a seat. Concern's position on the NWT has lead to great visibility for the organization and proved to be a position of significant influence.

5. Increased capacity of Municipal Authority and Municipal Health Staff

ALL 7 Municipalities have developed Annual Health Plans.
68 % MHS received at least one training
ALL 7 Municipal Cabinets and MHD have conducted a capacity self-assessment, facilitated by MHPP staff.
ALL 7 municipalities have appointed one Cabinet member to act as the health point person
50% MHS on Master Roll

Importance:

When the MHPP program started, planning for health was limited to a small single line item in the Municipal budget and no municipality had an annual health plan, written or unwritten. Health issues were seldom on the agenda of Cabinet meetings, as the Municipal Authorities did not believe they were responsible for the health of their citizens (see *Section O: Results Highlights*, highlight on MESPCC for explanation of gap in responsibility of health of municipal populations due to government structure). As a result of MHPP efforts, and the success of WHCs in mobilizing the population and giving a voice to the community, health issues are routinely a part of Cabinet meeting agendas in all seven municipalities. The development of detailed annual health plans is the most essential building block in the Municipal Health Departments' capacity to deliver on its responsibilities and contributes to the strengthening of the health system. More important than its existence is the use of the annual plan to guide activities throughout the year. Three municipalities (Kurigram, Nilphamari and Bogra) are leading the way, having established an annual plan review system to review progress on the plan every two months. The development of health plans, inclusion of health issues in Cabinet meetings, the appointment a Cabinet Member as a health point person and increases in the health budget (see item 6 below) are all promising signs of a major shift in the Municipal Authoritys' attitude towards their responsibility for the health of municipal populations.

MHS staff trained as facilitators are now conducting all CHV trainings, WHC orientations (teaching WHC members about basic health messages/practices and their roles), and Imam ToTs, with minimal support from MHPP team. This in turn has resulted in a new sense of purpose for the MHS staff involved, who exhibit greater enthusiasm and awareness of their important role in promoting the health of the population. This cadre of MHS trainers/facilitators are key to MHPPs sustainability efforts, especially since they can be expected to stay in their positions for an average of 5-7 years, unlike politically appointed positions which change frequently (every 2 years or LESS).

Contributing Factors:

Initial orientation and training at the Learning Centers focusing on major health issues, the Municipal Authority's role, and visits with Saidpur and Parbatipur Cabinet Members, WHCs, and MESPCCs created awareness and a vision for the future among Municipal leaders of the scale-up municipalities.

The Cabinet members and MHS of ALL seven municipalities participated in a 2-day workshop facilitated by MHPP staff where they conducted their first organizational capacity and viability assessment (tools based on Component 3 and 4 of the CSSA). Even though the assessments involve discussions of often sensitive issues among elected and politically appointed positions, the overall impression of Cabinet Members and MHS staff has been very positive, with many commenting that the assessment allowed them to see the big picture, what was and what should be in more concrete way.

6. Advancing the MHPP Advocacy Agenda to Strengthen Health System

Municipal Level: ALL 7 Municipalities increased total health budget (see table below)
2 municipalities have allocated funds to specific health related

activities (i.e. WHCs)

Approved Municipal Health Budgets:

Municipality	Previous Budget(BDT) (July '5 – June '06	Current Budget (BDT) (July '06 – June '07)	Remarks
Bogra	100000	300000	Major portion For WHC & Medicine
Dinajpur	265000	400000	
Gaibandha	Not clearly mentioned in previous budget	600000	WHC office construction and for MCH
Kurigram	Not clearly mentioned in previous budget	277000	The most of the amont for WHC office construction and MCH services
Joypurhat	Not clearly mentioned in previous budget	275000	MCH Services
Rangpur	2300000	4900000	WHC office and MCH services
Nilphamari	100000	2.5% increase	MCH services
Saidpur	165000	1.8% increase	WHC and MCH services
Parbatipur	135000	Same as before	Health activity budget remained same, but master roll staff salary increased from 1000TK to 1200 TK/month

Note: In addition to above funds, many municipalities also receive funds for other public health programs (i.e. Healthy City of WHO – garbage disposal, GAVI immunization program, etc.)

Importance:

Adequate funds for the health sector is of course one of the most essential ingredients for proper functioning of any health system. Moreover, even if small, an increase of the allocated budget is one of the strongest signs of a true shift in the Municipal Authority's commitment to health, elevating its status as a priority.

Contributing Factors:

The Municipal Authority Capacity Assessments directly lead to increases in the health budget of three municipalities and in increased support to the WHC (i.e. provision of official office space, etc.). See *Section F: Sustainability Measures* for further details on Municipal Authority Capacity Assessments (MACA). In addition to the positive impact of the capacity assessments, continuous formal and informal discussions by MHPP staff with Cabinet members were vital in securing the increases in the health budget of the four municipalities.

National Level: MoLGRD enforced municipal reporting system

In its effort to bring the attention of higher bodies of government to the gaps in the national health system impacting municipalities and the challenges faced by Municipal Authorities, the MHPP team began by lobbying the Commissioner (highest post) of the Rajshahi Division. The Commissioner agreed to call a meeting of all Deputy Directors of Local Government (DDLG-highest official of the national Ministry of Local Government, Rural Development and

Cooperation (MoLGRDC) at District level[1]. The purpose of the meeting held in March 2006 was to introduce these officials to the initiatives undertaken by the MHPP and the progress made; and ask the District Deputy Directors to oversee (and therefore enforce) the reporting system MoLGRDC itself decreed in the same government order from1995 which ordered the establishment of MESPCCs and WHCs.[2] It was agreed that the MA of each Municipality was to send a quarterly reports to the Divisional Director of Local Government for Municipalities, which would then be compiled and sent to the Secretary of the MoLGRDC (highest position in the Ministry).

Importance:

Enforcing the reporting system achieves two important goals. First, it supports the sustainability of MHPP initiatives by holding the MA officially accountable. This is especially important as leaders in office now with whom MHPP has built a strong partnership leave the position to their successors. Second, it will give the MHPP and its partners a way to draw the attention of the MoLGRD Secretary's (highest position of the Ministry) to the success of MHPP initiatives and the remaining gaps in the municipal health system, especially the need for increased municipal health budgets. The MHPP team is currently working on securing a meeting with the Secretary of MoLGRD&C with the support of a member of the PAC who currently holds the position of Senior Assistant Secretary of Local Government (national level).

Contributing Factors:

Along with the MHPP teams advocacy efforts, testimony from several Municipal Chairman, and other stakeholders demonstrating the support of Municipal Authorities for this measures was strong convincing factor for the District and Divisional level MoLGRD&C officials.

b) Brief Descriptions of Primary Accomplishments by Program Objectives

Objective I: Sustained Improvements in Municipal Health Systems

1. Reactivation and Development of Municipal Essential Services Package Committees (MESPC) into multisectoral platforms addressing gaps in the health system

See Section A, Part a*: Most Significant Accomplishments*, item number 1.

2. Formation and increased capacity of Ward Health Committees (WHCs)

See Section A, Part a*: Most Significant Accomplishments*, item number 3.

3. Increased capacity of Municipal Authority and Municipal Health Staff

See Section A, Part a: *Most Significant Accomplishments*, item number 5.

[1] Rajshahi Division → 64 Districts → 58 Municipalities (urban), 127 Upazilas (rural)

[2] The position of District Director of Local Government was selected partially due to the fact that it is a relatively stable political position (less frequent turnover).

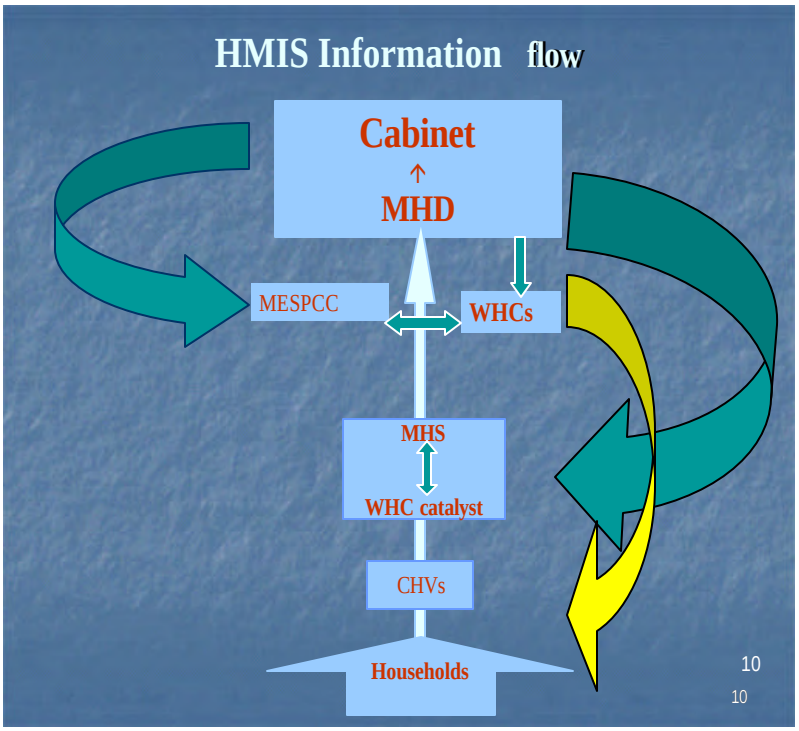
4. Advancing the MHPP Advocacy Agenda

See Section A, Part a: *Most Significant Accomplishments*, item number 5.

5. Roll out of HMIS Implementation

Currently, no comprehensive health information exists in any of the municipalities served by the MHPP. Some data is collected through several fragmented systems including birth registration, sanitation, and data collected at health facilities. Each of the latter types of data is reported into different agencies and never compiled, so that pertinent health data is not easily available to decision makers, if at all. The goal of the new HMIS system is to create a system for the collection of all health related data, compiled and analyzed regularly into comprehensive reports available to all relevant stakeholders. In this way, the Municipal Authority can easily provide information to the various government agencies requiring it and the MHD, WHCs, health related NGOs and other stakeholders can plan and make decisions based on reliable current information.

To overcome the barrier of low MHS to household ratio which makes the collection of data by MHS impractical, MHPP is proposing a CHV-WHC-MHS data collection network. This model is similar to the one introduced in the original CSP program in Saidpur municipality, with the crucial difference being a much stronger dual supervision system for the CHVs which we believe will eliminate the problems which plagued the earlier version (see schematic below).



Data Collection, Compilation, Analysis and Reporting Process:

1. CHVs collect data on monthly house to house visits (50 HH/CHV) and compile data into standard summary sheet.
2. WHC member supervises CHVs, providing support and collecting compiled summary sheets (1 WHC member/6-7 CHVs).
3. WHC members give summary sheets to MHS (MHD rep serving on WHC).
4. MHS monitor CHVs by conducting periodic field visits and bimonthly CHV meetings.
5. MHS compile all data, conduct analysis and provide report to all stakeholders, including WHCs, MESPCC, etc. for decision making.

The data collection tools (CHV registers, other forms, etc.) for the new HMIS system have been developed. A half day orientation has been conducted with the Cabinet and senior MHS of all seven municipalities focusing on the objectives, rationale and ultimate benefit of the HMIS. A

brochure summarizing the latter has also been developed for advocacy purposes, to begin laying the groundwork for further scale-up of the HMIS beyond the seven MHPP municipalities. The MAs of all seven municipalities have agreed to implement the new HMIS.

Roll-out of the new HMIS began with a 3 day training of selected staff of the MHDs from all seven municipalities. Trained MHS staff have begun training other health staff, selected WHC members and CHVs. Plans are underway to develop an access database for the MHDs to house and analyze HMIS data.

6. Piloting Rapid HFA

A consultant from CSTS+ and a team of MHPP staff conducted the Rapid HFA pilot in four health facilities. The pilot was successful in illuminating issues of validity, reliability and feasibility of the indicators and instruments used. MHPP is planning to use the Rapid HFA to conduct the Municipal Diagnosis set to take place every six months beginning DIP year 3 and include assessment of all health facilities serving the municipal population, including district hospitals.

7. Operations Research: Cost-Effectiveness Study

Per the recommendation made in the final evaluation of the original CSP program in Saidpur and Parbatipur municipalities, a cost-effectiveness study is being undertaken in the attempt quantify the total input of resources (including direct and opportunity costs) necessary to achieve the results attained by the MHPP.

A team including a financial expert from Concern headquarters in Dublin and a consultant from Johns Hopkins University conducted initial qualitative research, primarily via a series of interviews with MHPP staff and key partners (Government officials) and a review of financial and other documents, in order to develop the processes to track the necessary data.

As a result the following measures were put in place:

- For practicality, all MHPP activities were divided into five major categories
- A financial tracking and analysis system (including development of necessary tools/forms) based on the five categories
- MHPP staff asked to complete monthly timesheets based on the five categories, which are compiled, converted to financial cost equivalents and entered into the master financial tracking system

A number of methods for tracking of the time and other resources spent by WHC members and Government officials are under discussion. A decision will be finalized shortly.

Objective II: Improved Preventive and Care-seeking Practices for Sick Children

1. Training and Progress of CHVs

A total of 1,297(38% of the total needed) CHVs selected by their respective WHC, have been trained by MHS trainers. Selection and training of the remaining CHVs, including positions to

be filled due to turnover is ongoing, although at a slow pace due to shortage of MHS. In addition, CHVs already in place are being trained on their role in the HMIS.

The CHVs, a new cadre to the municipalities, are proving to be a great success. The major indications of this are highlighted below:

- Although predominately young, often unmarried, women (avg age 16-20), the vast majority of CHVs are highly respected by the local communities they serve, as observed by WHC members. The fact that all CHVs are educated and that a large portion of mothers are young and so feel comfortable as they are talking to their peers, are contributing factors.

- Several clinics have reported seeing a noticeable increase in referrals, often accompanied by CHVs, demonstrating CHVs' dedication to individual community members and ensuring they receive care.

- CHVs have been responsible for saving many lives by taking appropriate, rapid action in emergency cases (See ANNEX A: Case Studies for examples).

- MHS supervising CHVs report that more than 90% are performing well (dutifully performing their responsibilities, well known in community they serve, etc.)

2. Training of Imam Trainers

Twenty seven Imams have been trained by MHS on key health and hygiene messages including C-IMCI related messages and have begun training to other Imams, with the goal that 100% of Imams preaching in the seven municipalities will receive training by end of DIP year 3. The training materials, developed by a selected group of Imams, use versus from the Koran to promote good health and hygiene practices.

Initial feedback from MHS and project managers monitoring Imam trainers, indicate that more than 80% of the Imam trainers are conducting trainings effectively. The remaining 20% appear to be in need of a refresher on some of the course content. Already a change is taking place in the attitude of trained Imams; for example many who used shun any form of abstinence and contraceptives for married women of reproductive age, have now toned down their messages on this and other controversial topics with negative health consequences.

3. Operations Research: Indoor Air Pollution (IAP)

The IAP study, in collaboration with Loughborough University (UK) and Winrock International (US), aims to measure the extent of hazardous indoor air pollution in the poorest households and introduce behavior change methods including the use of special ovens to reduce the communities' exposure to IAP.

The study has adopted two primary approaches, social marketing for the stoves and a Behavior Change Communications (BCC) campaign to raise knowledge and awareness; and reduce

harmful practices. Concern is responsible for the BCC component. The following are the accomplishments to date:

- Cabinet Members and WHCs in all seven municipalities have been oriented regarding the study and any changes necessary in their annual plans due to study related activities have been incorporated.

- A training module and communication tools have been developed for CHVs who have been adopted as the primary channel of communication with the households in the study.

- Planning is under way for a message development workshop and field testing of communication tools for adolescents, recruited to disseminate messages to households.

Objective III: Improved Maternal and Newborn Care Practices

1. Building a strong relationship with the Directorate Generals of Health and Family Planning and MCWC doctors.

See *Section a: Most Significant Accomplishments*, item number 2 and *Section O: Results Highlights* for further details on the role of Centers of Excellence.

2. Training CBAs

The revision of the CBA training curriculum was completed by LAMB with input from Save the Children US, WHO, NSDP, ICDDR'B, CCDB, OGSB, Radda-Birnen Organization, BRAC, AD-Din Hospital and Directorate Generals of Health and Family Planning at a national sharing meeting. The manual is now awaiting final approval from the DGFP with trainings expected to begin November 2006. WHCS in all seven municipalities are in the process of selecting 3-5 CBAs per ward according to specified selection criteria.

3. Implementing the Behavior Change Communication (BCC) Strategy

All 7 MESPCCs have nominated representatives to the Inter-Municipality Behavior Change Team (IMBCT). First IMBCT meeting to be held November 2006.

4. Implementation of the MAMAN Minimum Package

On August 31, 2006 Concern participated in a national sharing meeting for the MAMAN maternal and newborn care framework. The implementation of the minimum facility and community based activities recommended by the MAMAN framework within MHPP interventions was reviewed in a meeting held with CSTS advisor Michel Paque in Bangladesh in early September 2006. The MHPP program was found to be addressing the practice of all MAMAN minimum package activities to some extent. Three areas were identified as areas where stronger interventions should be considered. These include newborn resuscitation (use of ambient bags), use of partographs and management of third stage labor. The first two

practices have been adopted by the MoHFW as national policy. However, management of the third stage labor is not yet national policy and therefore more difficult to promote locally. Nonetheless, one doctor at every MCWC has already been trained in the method by LAMB as part of a previous program. MHPP managers are currently considering the feasibility of additional actions to strengthen MHPPs intervention in the three recommended areas. All MAMAN indicators not already tracked will be incorporated into MHPP's monitoring and evaluation process in year 3 of the program.

c) Activity Chart by Objectives and Technical Interventions

(Source: MHPP Monthly Activity Reports from October 05- July 06)

Key activities	Status of activities	Comments / Remarks
Objective 1: Sustained municipal health systems for maternal and child health in seven municipalities		
Ward Level		
Formation of 75 WHC (15-20 Member per Ward)	Achieved 100%	61 Ward Health Committees was formed during year-1 out of total 75. Being people representatives Commissioners had to involve with other priority business caused deviation of WHC formation plan. On the other side, previous learning evidences that commissioner's active leadership and much more involvement in formation process is very much important. So program considered the delay formation of rest 14 numbers of WHCs for its future sustainability.
WHC orientation and priority development (action plan)	Achieved Orientation 79%, Micro plan 82%	60 Ward Health committees was provided a two day-long basic orientation course containing members roles and responsibilities, and basic knowledge on health messages. The orientation course also provided the members how to improve interpersonal communication, inventory and use of local resources. After immediate orientation most of the WHCs developed ward level micro plan followed by ward priority and municipality annual health plan. 2 WHCs in Bogra municipality developed micro plan early, in year-1, and 59 WHCs did it during the reporting period. In the planning process most of the members of WHCs, community channels (CHV, TBA, Imam, and teachers) was involved and participated from their respective position.
Monthly WHC meeting	Achieved (continuous process)	All the WHCs are conducting regular monthly meeting. Last meeting of the quarter is considered quarterly meeting, when plan vs progress is shared and the forum makes data based decision. Generally meeting contains the discussion on day to day performing activities and for arranging special event like day observation. Record to date, All the WHCs arranged average 67% of planned meeting, where 72% of the member participated.
- Facilitation Skill development training for MHS on capacity assessment and - WHCs self capacity assessment	In the process	With technical support from Concern USA (Inc.) revised tools and facilitation guide for WHC capacity assessment is in place. Most of the WHC members' view, it is very much preliminary stage now. So it would be better if they start assessment later in 2nd quarter of year-3, which can be helpful

Key activities	Status of activities	Comments / Remarks
		to understand and active participation and contribute for members. Project idea is to conduct the WHC capacity assessment after immediate facilitation skill development training of MHS/WHC member secretary.
WHC Annual progress sharing meeting at municipal level	In the process	Most of the WHCs formed in early 2006. Now they are much more involve in their structural development like training, selection and training of CHVs, Imam and school teachers. More over, their plan did not match with reporting plan. WHCs micro plan follow January –December. So in December 2006, most of the WHCs' annual progress sharing would be taken place.
WHC support mechanism development for Least Advantaged Groups	Achieved Partially	Almost all the WHCs has started a process to address the poorest. As part of this process some WHCs created fund and developed fund management guideline. The list of Least Advantage Group (LAG) by some (17%) of the WHCs is in place. NSDP is the partner of MHPP, whose role is to provide low cost service for the poorest, and WHCs has started to refer the client to NSDP. They are going to introduce a referral slip.
Day observation, community gathering and messages dissemination activities	Achieved	The BCC messages developed in the original program has been disseminated through a number of channels to community under the leadership of Ward Health Committees. The events includes 4 days observation (World Health Day, World Breast Feeding week, Safe Motherhood Day, World AIDS Day), Health Fair, ideal father and mother selection and rewarding, baby show competition, posturing, and group discussion. Community Health Volunteers are in front line demonstrator to passes away the messages in the community.
Leadership Development Training for WHC Leader	In the process	Every Ward Health Committees have a culture of alternative leader but not use in same terminology to avoid the conflict between commissioners and those peoples. Just there is a decision who would lead the committee activities in case in absence of commissioners. Generally, This role is played by member secretary or potential members. Planned training is designed for mentioned three persons (commissioners, member secretary, and potential members).
Cross visit for WHC Members	Continuous	Some WHC has already started the process and some are getting preparation. The event aim is to fostering learning culture across the WHCs, which promotes for more functionalisms and towards sustainability.
Municipality Level		
MESPCC Quarterly Progress Sharing Meeting	Achieved 90%	Program initiated intensive efforts to reactivate MESPCC and ensure effective collaboration among the members (municipality, representatives of GO NGO health facilities) for establishing a common platform to address the health issues. The efforts came to success in the mid of year-1 resulting regular conduction of meeting with

Key activities	Status of activities	Comments / Remarks
		significant number of members representation, and issue based discussion. Record shows 90% of planned meeting held with 73% attendance.
Training on Participatory Management for Cabinet	In the process	
Training on Supportive Supervision Technique for MHS & Supervisor	In the process	
Training and Introduction of HMIS	Achieved partially	The events were started in the late of DIP year-1 and continuing till in fact. Followed by HMIS evaluation in learning center, ICDDR'B facilitated a day long orientation with cabinet and key staff of health department in the seven municipalities. The orientation resulted a shared understanding of the cabinet and MHD about the objectives and benefit of Health Management Information System. In the early of DIP year-2 ICDDR'B also facilitated a three-day long training (TOT) with MHPP team members and 16 staff of health department (at least two from each municipality) of the municipalities. TOT recipient MHS is going to arrange training at municipality level with all health staff, WHCs' selected members and CHVs followed by revised approach of HMIS.
Municipal Annual Health Plan Development (Workshop)	Achieved	All the seven municipalities has prepared annual health plan through a day long workshop arranged locally. Cabinet members, secretary and health dept. participated in the workshop. Concern MHPP regional team facilitated the session. Activities were explored through dreaming exercise, considering KPC and municipality capacity assessment findings. In the municipalities where municipality capacity assessment workshop conducted later and plan prepared earlier, it was reviewed considering capacity assessment workshop.
Municipality Capacity Assessment	Achieved	All the remaining 5 municipalities conducted Municipality Capacity Assessment through a two day long workshop. Appreciative Inquiry methodology was used as process in the workshop. The workshop introduced cabinet members to a new appreciative process that leads to identify their capacity strength. Findings have been displayed at every municipality as pictorial monitoring system. Findings have also been used in municipality annual planning.
Research findings sharing with stakeholders (Finding of Doer & Non Doer, IAP Base line, Economic Cost Analysis)	In the process	Doer non doer analysis conduction is under the process. IAP baseline findings were shared with Saidpur, Parbatipur municipalities and WHCs. The Operations research, Economic Cost Analysis is being implemented. Study outline have been shared with municipality cabinet and selected WHC members
Learning center (need to check by liaquat Bhai)		
Advocacy for increasing health sector budget allocation	Achieved	This is a continuous process in the learning center. A significant outcome has made Parbatipur

Key activities	Status of activities	Comments / Remarks
		municipality increasing master roll staff salary from TK 1000 to TK 1200, and constructing building of WHCs permanent office. Both Parbatipur and Saidpur municipalities' increases regular staff salary followed by GOB salary structure.
Progress sharing meeting with CHV	Achieved 72%	Parbatipur municipality is organizing meeting with CHVs regularly and efficiently. Records from October 05-June 06, 72% of the planned CHV meeting was arranged by WHC with 72% attendance. Saidpur municipality did better in attendance of meeting (78%) than number of meeting conducting, 35%.
Progress sharing meeting with TBA	Achieved	NSDP clinic is arranging meeting with TBAs at their office in case of Saidpur municipality. From October 05-June 06, they arranged 65% of planned meeting with 76% attendance. Parbatipur municipality female health staff arranged and facilitated the meeting with TBAs. Up to June 06 they arranged 66% of planned meeting with 65% attendance.
Progress sharing meeting with Imam & Teacher	In the process	
WHC Progress sharing meeting (monthly)	Achieved	Parbatipur municipality is arranging this meeting regularly. Data from October 05-June 06, 73% meeting was held with 79% attendance up to June 2006. Saidpur municipality claimed 73% with 37% of planned meeting.
Lesson learned sharing with stakeholders	Achieved	This is a continuous process. It is being shared during the visit of stakeholders at learning center.
MESPCC progress sharing meeting	Achieved	Going as continuous process.
Host exposure visit	Achieved	Going as continuous process as per plan.
Continuous implementation of HMIS	Achieved Partially	Parbatipur is implementing with revised tools, but data is not shared in the WHC and MESPCC forum. Saidpur municipality is going to follow revised approach (by program). Health staff was provided training on revised tools, and facilitation technique to mentor CHVs in data collection.
Documentation of LC experiences	Achieved	Project Manager- LC is keeping record of regular activities and compiling it as monthly report. Learning and Documentation Manager is reviewing the previous document to keep it in program resource center which is new innovation of Concern Bangladesh.
Review and update of HMIS	Achieved	ICDDR'B provided technical assistance to review the system through formal evaluation on HMIS implementation in learning center. Updated tools and system is being scaled up in the new 7 municipalities.
Follow up of on-going health activities at Municipality & WHC (capacity assessment) and prepared periodical report	Achieved	Both municipalities reviewed municipality capacity status through two days long workshop. The workshop used Appreciative Inquiry methodology. Consequently municipality and WHC reviewed annual plan progress and developed new plan

Key activities	Status of activities	Comments / Remarks
		considering priority issues.
Sharing the lesson learned with Project team	Achieved	This is a continuous process and is being shared during quarterly meeting and annual retreat by Project Manager LC. Other managers in new sites are replicating the learning where applicable.
Sharing research findings with stakeholders(Finding of Doer & Non Doer, IAP Base line, Economic Cost Analysis)	Achieved	Early mentioned
Host IMBCT Team Training & Follow up	Achieved	All the 32 members of IMBC team would be provided an orientation at the end of September 06 in Learning center, Saidpur
Regional office level		
Regular program review and learning sharing by MHPP team	Achieved (Continuous)	Team shared plan vs progress and learning during quarterly meeting. It is a regular event as an internal activity monitoring system. All the members of the team participate in these events and shared the progress from projects team and others desks based in the region. Participatory discussion on Causes of deviation takes place in the forum. The events also contribute for database decision and plan of action.
Program Rapid Assessment	Achieved	The study was conducted keeping in mind following objectives - To present the progress of household level practice and care seeking behaviour of communities -To compare the progress with benchmark as well as program plan - To identify priority areas at ward level - To contribute project management in developing action plan considering study findings Study findings is planned to use internally to serve the mentioned purpose. To minimize time and resources 50% of the population was covered in the study. Data analysis is in place, and findings are expected to incorporate in the report.
Staff development in Research and Learning		
Research Methodology training for team	Achieved partially	Research team participated in an advanced training course on Applied Research Methods. But a basic orientation on research methodology is on the process. The orientation course is designed with priority contents LQAS as it is being exercised in the program.
Development Management Course for SPMs & PMs	In the process	
Advance training on materials development for Training Team	In the process	
National level/advocacy		
Project Advisory Committee arrange semi-annual meeting	Achieved	PM to write

Key activities	Status of activities	Comments / Remarks
Develop Operational Manual	In the process	LOD to write
Objective 2: Improved household prevention and care practices for sick children		
Ward level		
Selection and training of community health volunteers-CHV(50 House hold per Volunteer)	Achieved	CHV selection is almost complete and training is being provided as per project plan. Health staff is facilitating the CHV training session with mentoring support from Concern field trainers. Training duration is three days long, and arranged by Ward Health Committee at local venue. Basic health messages, danger sign identification, improving interpersonal communication skill are the major contents of the training.
-CHV Monthly Meeting, -CHV Annual progress sharing meeting (70% meeting conduction targeted) - CHV Refresher Training	Achieved Continuous	Ward wise CHVs' regular meeting held bi monthly under the facilitation role of health staff. WHCs decision and plan, and CHVs recommendation are interchanged by CHVs representatives in the WHC. The said CHV representatives in the WHC bring the recommendation/agenda in the WHC meeting and provide feedback /solution to the CHVs in the next CHV meeting. CHV annual progress sharing is the part of WHC micro plan. This is planned at the end of this year, December 06. Training team is working for developing a module on CHV refresher training.
Selection and Training of PP Moderators (4-5 MBBS doctors per Municipality)	In process	FGD was commenced with Homeopath doctors. PP guide was filed tested in Dinajpur municipality.
Selection and training of PPs (RMP-3+ Homeopaths-2 total-5 per Ward)		
Selection and training of School teachers and religious leaders	Achieved Partially	27 religious leaders was provided TOT course on basic health aiming to train up religious leader in the ward level. Respective WHCs selected them from different mosques of the wards. According to plan 6 Imams/religious leader per ward would be selected for training. Imams would be conducting mosques based health education and disseminating messages to their neighbors at community. WHCs' primary school teachers' selection process is in place. Training team is working to develop a module for their training. Teacher is considered channels for school based health education and disseminate messages to their neighbor.
Municipality Level (new 7)		
Launching C-IMCI at municipality level	Achieved	Followed by national level workshop and endorsement, Community-IMCI was launched at municipality level during the reporting period. The event was taken place through a day long workshop with the participation of municipality cabinet, Civil Surgeon, DD-family planning, MO-clinic and MO-MCH.
Formation and semi-annual meeting of municipal IMBCT	Achieved Partially	All the municipalities in the project location including learning centre formed IMBCT which is consists of 32 members. The team includes 4 members, health education officer of CS office, WHC representatives, MHD in charge and TBA representatives from every new municipality. Learning centre incorporated total 4 members (2

Key activities	Status of activities	Comments / Remarks
		from Parbatipur and 2 from Saidpur). Every municipality decided quarterly meeting at municipality level. By this period Bogra municipality arranged a meeting with its 4 members of IMBC team. The team is going arrange semi-annual meeting in learning center in late September 2006.
Learning center		
Facilitate BCC activities as per BCC strategy	Continuous going on	
Establishing referral tracking of PP with TBA	On the process	
Follow up HMIS activities	Continuous	M&E team and Project Manager- LC is facilitating the implementation, and is being followed up regularly.
Continue PP negotiation session (80% Meeting Targeted)	On the process	
Research		
Impact on PP Negotiation sessions (Case management, Timely referrals)		This is marched to year-3
Effectiveness of IAP interventions	Achieved	Learning centre, Parbatipur and Saidpur is piloting IAP interventions in partnership with VERC and Winrock In. BCC messages was developed and is being implemented via folk son and video show in the community.
Health Facility level		
F-IMCI training for GOB/NGO service providers (11Days)	Upcoming	Technical Manger- IMCI is facilitating the training session with GOB staff.
Training of MHS on C-IMCI *(3-4 Days)	On the process	
National (IMCI Linkage)		
Launching of C-IMCI (Regional)		Launching was made in all the 9 municipalities of project location, where regional level stakeholders participated. So the event was not considered as priority.
Launching of C-IMCI (National)	Achieved	It was launched at national level with the participation of GOB, IMCI working group (GO, NGO) and other relevant stakeholders.
Participation at IMCI National Working Team (NWT) meetings	Continuous	Concern is an active member of the IMCI NWT and attends meetings and national IMCI events on a monthly basis. We are exploring opportunities with CORE to increase collaboration with PLAN, Save the Children and CRWRC to increase NGO participation in national application.
Development of PP training guide based on National IMCI guidelines	Achieved	Guide has been developed, field tested and finalized with the endorsement at national level.
Field testing of PP training guide	Achieved	
IMCI Case Management Training for MHPP IMCI Technical Manager	Achieved	Technical Manager-IMCI participated in the training. Two project Manger (medical graduate) would be participating in early year-3.
IMCI facilitation Training 5 days	Completed	Technical Manager-IMCI participated and two Project Manager would participate after 11 days basic training.
IMCI Follow-up after training 5 Days	In process	Technical Manager-IMCI would participate

Key activities	Status of activities	Comments / Remarks
Participation in National training pool for C-IMCI	continuous	Concern –MHPP is the member of IMCI national training pool. Program manager and SPM operations participated in that training that was taken place at Serpur, Bogra, where IMCI would be pilot tested.
Learning Visits to Dhamrai/Kahalu For community IMCI exchange	In the process	The site decided Motlob of ICDDR'B field in lieu of Dhamri.
C-IMCI Learning Visit, Nepal	In the process	In consultation with Health Advisor at New work the visit is on the process for December 2006.
Objective 3: Improved maternal and newborn care practices in 7 municipalities		
Ward Level		
Selection of TBAs based on GOB TBA selection guideline	Achieved Partially	CBA selection guideline has been endorsed by GOB. Currently GOB is addressing Skill Birth Attendant(SBA) in lieu of TBA experiencing low level outcome. But program is addressing TBAs in named CBA from previous learning in Saidpur and Parbatipur municipalities, which evidenced significant outcome. The approach complements national policy in lieu of contradiction. CBA selection guideline is in place with consultancy support from LAMB Parbatipur. WHCs have started to identify CBAs as per guideline.
Health Facility Level / Center of Excellence		
Select 'Center of Excellence' & Finalize MoU/letter of support with relevant authorities	Ongoing	Maternal and Child Welfare center of every municipality have been identified and selected as 'Center of Excellence'. Formal and Informal communication with MO-MCH is in place to conduct CBA training there. Communication with DD-FP and MOHFW is in place for a letter of support and finalize MOU.
Update TBA curriculum with life saving skills and Essential Newborn Care	Achieved	LAMB Hospital has reviewed TBA curriculum of GOB with consultation to GOB body, and introduced revised one nationally through a workshop. It is under process of endorsement at DGFP Office.
Training of TBA Trainers under Center of Excellence Health Facilities	Achieved	LAMB hospital Parbatipur arranged 7-days long Training of Trainers training for FWV followed by revised TBA training curriculum. FWV would be providing training to CBA at 'Center of Excellence' .
Training of TBAs based on revised TBA training guideline	In the process	The training of CBAs (formerly TBAs) would be held at government facilities and the program is ready to start it after getting endorsement of DGFP.
Refresher Training of Trained TBAs by TBA Trainer.	Not yet done	It would be started after some batches of CBA training is completed
Establish system of tracking TBA Referral to health Facility	Not yet done	Depends on TBA training at COE.
Orientation on MNC for MESPCC members	Achieved	LAMB hospital provided technical support and facilitated to conduct this thematic updates in regular MESPCC meeting of municipalities.
Quality Assurance Orientation and self assessment for MESPCC members	Achieved	LAMB hospital facilitated the session with MESPCC members .

Key activities	Status of activities	Comments / Remarks
Municipality diagnosis(Service, QoC, Referral & community function)		It has been shifted to year-3 in annual retreat of Y-1
Update Emergency Obstetric Care-EmOC and Perinatal Audit training	Achieved	LAMB has updated the course incorporating relevant latest info on the issue.
Conduct EmOC and Perinatal Audit training	Achieved	Out of total 14 doctors, 5 participated in PNDA and 10 doctors participated in MOET training at LAMB in the 1st batches; the rest of the doctors are ready to participate in 2nd batch of the training, which are expected to be held after Feb 2007 due to LAMB Trainers unavailability before that time
Technical update (ANC, Birth preparedness, Post natal) to MESPCC members.	Achieved	LAMB hospital provided technical support and facilitated to conduct this thematic updates in regular MESPCC meeting of municipalities.
Learning visit to LAMB's safe delivery Center by Municipal Stakeholders	In the process	
Support to Center of Excellence for quality improvement	In the process	The Training on MOET & PNDA for the doctors of COE are the 1st step. Implementing process of PNDA in the DIP Y-3 would be the next step towards the quality improvements; The semi-annual diagnosis in the DIP Y-3 would support the program further in improving quality in the facilities.
Research		
Doer/ Non-doer analysis on Iron folate supplementation, food intake during pregnancy, Delivery at Health Facilities	In the process	IMBCT has been formed, an workshop of the team to identify the priorities and planning would be held in last week of September;
Operation research on Impact of WHC social and financial support in maternal and newborn emergencies at learning center.		
National Level		
National platform to review and endorse revised TBA curriculum	Achieved	After a national sharing and incorporating suggestions from government and NGO participants, the revised CBA (formerly TBA) curriculum is in the desk of DGFP for final endorsement.
Participation in maternal and newborn health forums (from Concern and or Municipality) and sharing with team	Achieved	It is going on as continuous process. Technical Manager-MNC participated White Ribbon Alliance forum, NSDP and LAMB forum.
Sharing of Health Facility Assessment report	Achieved	The draft report was shared in a national meeting with national and district level authorities from Health and Family Planning department and has been accepted by all with some positive input.

B. Constraints and Challenges

a) Constraint: Inadequate and Unmotivated MHS

Issue:

With the exception of Rangpur and Joypurhat Municipality, the remaining six municipalities are facing up to a 70% shortage of MHS. One or more of the following situations are true for the five municipalities facing shortages: Not enough positions have been allocated; positions are vacant; MHS staff are sharing their time with other departments. In addition, many MHS are receiving low pay and/or their pay is often delayed for months. Although many MHS staff, especially those trained as trainers/facilitators, are showing increasing pride in their positions, the significant increase in responsibilities resulting from MHPP interventions combined with low and/or irregular pay has become a major demotivating factor for a large number MHS. Exacerbating the situation, are is the fact that 50% of MHS who are on Master Roll, meaning they are contractors with no benefits and no job security.

The position of Medical Officer, which serves as the head of the MHD, has caused the most concern, as it is often left vacant due to the lack of opportunity for upward mobility, and worse no one is put in charge during the interim. Two years ago MoLGRD recruited Medical Officers for all nine municipalities (including original two), today five of those positions are vacant.

Impact:
The shortage and lack of motivation of MHS staff is impeding the timely implementation of activities. The slow progress in training CHVs (less than 40% have been trained to date) is one example of activities negatively impacted by the shortage of staff.

The lack of Medical Officers and therefore an effective leader for the MHD has also slowed progress and effected oversight of WHCs.

Actions to Overcome:
Continuous advocacy by the MHPP team, at Municipal and higher levels, has yielded some results as follows:

- The Municipal Authority's of several municipalities approved the rearrangement of responsibilities, relieving some congestion
- Regular MHD meetings have resulted in increased job satisfaction by creating a forum for staff to voice concerns (i.e. lack of desks or allotted space to work)
- Nilphamari municipality has made an official request to Mo LGRD for additional staff

Advocacy to ensure regular pay for MHS is ongoing.

b) Challenge: Other NGOs looking to create new overlapping structures

Issue:

Several NGOs implementing health related projects in MHPP areas sought to create new community based committees with overlapping mission and purpose.

In Kurigram, Rangpur and Gaibandha Municipalities, the USAID- funded SHOUHARDO program of CARE Bangladesh was looking to start a new program focusing on slum dwellers, which included the formation of a community based committee as part of the intervention.

In Bogra Municipality, NICARE was looking to establish a committee of community members to serve as an advisory body to its clinics.

In the Learning Center municipalities of Saidpur and Parbatipur, GAVI has instructed the MoHFW to create a separate committee to manage the 10,000 Taka ($165) per month it will be providing the municipalities for the next five years to support immunization activities.

Impact:
Creation of additional structures, all requiring leadership from already overextended Commissioners and other community leaders, would jeopardize the success and most importantly sustainability of all such structures.

Actions to Overcome:
Acting promptly, senior MHPP staff conducted a series of meetings with the regional and national offices of CARE and NICARE to discuss the mission and scope of the WHCs and MESPCCs and the goals of the other NGOs' programs. After the discussions the organizations agreed that the WHC would be an appropriate forum to meet the goals of the initiatives in question, all looking to reach the poorest and disadvantaged populations of the community. The organizations also agreed that working together to strengthen the WHCs would be the most sustainable and beneficial option for the community.

In the case of the GAVI committee, the MESPCC of the municipalities have expressed their concern to the MoHFW through the Ministry's local officials explaining that the MESPCC is the proper forum for such committee and a separate committee would be redundant. There has been no definitive decision made thus far and no GAVI committees have been formed. The issue was also raised at a PAC committee meeting (the USAID mission is a member). The MHPP staff is seeking a meeting with GAVI representatives in the country.

c) Challenge: Inactive WHCs

Issue:
Although many WHCs are progressing well and some showing exemplary progress and innovation, one of the greatest challenges of the MHPP program remains the strengthening and institutionalization of the WHCs. The comprehensive study of WHCs conducted by the MHPP team this year showed that the majority of faltering WHCs have one or more leaders (Comissioner or Member Secretary) who have not proven to be committed in their actions (see table below).

Status of WHCs of the Seven Scale-Up Municipalities:

WHC Monitoring Indicator	# requiring special attention	% requiring special attention
WHC Functionality	26 out of 66	40%
Commissioners	23 out of 66	35%

Member Secretary	23 out of 66*	35%
Chairman – Neg attitude towards MHPP Has conflict with commissioners Low MHPP/WHC event participation	 1 out of 7 4 out of 7 4 out of 7	 14% 57% 57%

* Poorly performing Member Secretaries not necessarily from same ward as poorly performing Commissioner.

The comprehensive analysis revealed the following key factors impacting the function of these WHCs:

- New Commissioners taking over, not familiar with the WHC and their role as its leader prior to winning the post, lacked commitment, despite initial orientation. Many are more concerned with infrastructure development or their personal businesses.

- The vast majority of the WHCs doing poorly in Saidpur had the same Member Secretary (MHD representative). This individual was a health inspector assigned to 6 WHCs. The recommended number of WHCs each MHS is to serve on is 3. Overextended between his responsibilities as an inspector and to the WHCs, this individual did not perform his function well and caused problems within the WHCs.

- In some WHCs, the Commissioner and Member Secretaries had misunderstandings, overstepping each other's role.

- In several municipalities, the Municipal Chairman and Commissioners are at odds due to heightened political tension.

- Many of the failing WHCs do not have a secondary leader in place.

Impact:

With 99 WHCs in the program area, all functioning on a voluntary basis, it is expected that some will not fair as well. However, it is very important for the sustainability of this model to closely monitor the WHC's progress as the MHPP program is doing, and fully analyze the factors impeding the poorly functioning WHCs so that, not a quick fix, but a systems based solution can be implemented to minimize their collapse. To this end, the MHPP being an extension project is an advantage as it allows us to see the reality of what occurs once direct support is removed, yet have the ability to intervene before it is too late and address the issues, bolstering sustainability.

Actions to Overcome:

After conducting a comprehensive ward by ward analysis for every municipality, including the LCs, a detailed plan of action was developed to address the issues identified and is being carried out accordingly. Some of the initiatives being carried out include:

- Encouraging WHCs to appoint the Female Commissioner (1 for every 3 wards) as the secondary leader

- This situation has brought to light the need for periodic comprehensive review of the status of all WHCs and Concern need to transfer its overall monitoring role. The logical candidate for such a responsibility would be the Medical Officer who leads the Municipal Health Department. However, as in many municipalities the Medical Officer position remains vacant for extended amounts of time or faces frequent turnover, secondary solutions are being sought.

d) Challenge: Lack of Referral Tracking System

Issue:
Although the program is having much success in recruiting and training CHVs, CBAs and PPs, an effective method to track their referrals to the health facilities has not been found. The most common solution, use of referral slips, is being considered however currently health facilities do not have the capacity or systems in place to track referrals.

e) Challenge: Elections and Political Turnover

Issue:
Currently, Bangladesh is preparing for national elections. Political tensions are high, especially as the current government is accused of unfairly manipulating pre-election/election procedures. Opposition parties are staging numerous local and nationwide strikes (*hartals*). The interim government that takes over for the several months before the elections and the incoming government may result in significant changes in government officials TWICE in a short period of time.

Impact/Actions to Overcome:
Due to the hartals Concern offices have had to close during some weekdays. This has not had as much impact on MHPP operations as the staff makes up days on Saturdays. However, the heightened political tensions make this a challenging time for MHPP staff, who MUST not be seen as partial to any parties. As such the staff is maintaining maximum vigilance in their words and actions during this time. To limit the impact of changing government officials, the MHPP team is focusing on strengthening relationships with government officials whose positions tend to be less transitory.

f) Constraint: Other NGOs Offering Material and Cash Support Jeopardize Commissioners' Spirit of Volunteerism

Issue:
Some international NGOs with projects in MHPP areas are offering monetary or in-kind (equipment) incentives which is having is resulting in Ward Commissioners having similar expectations from Concern and less willingness to offer their time voluntary.

Impact:
In some wards this is hindering the development of WHCs and Commissioners' cooperation as Cabinet members regarding MHPP activities.

Actions to Overcome:

The MHPP team is discussing the issue with those who have such complaints and reminding them of the importance of sustainability. They have been able to placate some individuals but the issue is still looming.

C. AREAS REQUIRING TECHNICAL ASSISTANCE

For the successful accomplishment of program results the areas for the technical supports are:

- Drawing attention of key policy makers
- Cost Effectiveness study
- Mid Term Evaluation

Drawing the attention of Key policy makers: Senior Advisor's support would be needed in endorsing the training curriculums which are developed by MHPP training team. After endorsement it could be effective tools for other implementers. A meeting at Ministry level headed by Secretary of MOLGRD could be very much supportive for program. Need Senior Advisor's support in this regard.

Cost Effectiveness Study: Need assistance from Health Advisor New work on further development of Cost effectiveness Operations Research. Community and Government part is still to be grounded.

Mid Term Evaluation: An external evaluator would be hired for the program midterm evaluation. Needs support of Health Back stop support from Concern USA.

D. SIGNIFICANT CHANGES IN PROJECT DESIGN (per original DIP)

The position of Senior Project Manager (LOD) was renamed as SPM (Operations) and Two SPM (Operations) hired instead of one for better field operations. Both the SPM (Ops) would be working till the end of Year -3 of the programme and from the Year -4 one SPM (Ops) would be continuing.

E. MONITORING and EVALUATION: Rapid Assessment Results

a) Key monitoring indicators for MHDs, WHCs and MESPCCs through September 30, 2006 based on monthly Project Manager reports.

Planned Activities	DIP Year-2 (Oct'05-Sep30'06)		% of Cumulative Achievement to Final Target
	Cumulative Target	Cumulative Achievement	
Formation, of WHC (No. of WHC)	75	75	100.00%
Orientation/Basic Training package for WHC members (No. WHC)	75	66	88.00%
WHCs' members received orientation/basic training. (No. of Members)	1514	1222	80.71%
Monthly meetings of WHC (No. of Meeting)	900	583	64.78%
WHCs recorded meeting (monthly) minutes	900	579	64.33%

regularly (No. of Meeting)			
WHC members participated in the monthly meeting (No. of Members)	11121	7832	70.43%
WHC Annual plan development (No. of Municipalities)	75	65	78.00%
WHC support mechanism development for Least Advantaged Groups (No. of WHC)	75	16	21.33%
WHCs have financial guideline for fund management	75	30	40.00%
Municipal Annual Health Plan Development (Workshop) (No. of Municipalities)	7	7	100.00%
HICAP Workshop (No. of Municipalities)	7	7	100%
Municipality formed IMBCT (No. of Municipality)	7	7	100%
Municipalities expanded MESPCC members involving multisectoral programme (people) (No. of Municipality)	7	7	100%
MHS received at least one training which provided by MOHFW (No. of MHS)	99	67	67.68%
Municipality developed annual health action plan (with contribution from WHC) (No. of Municipality)	7	7	100%
MESPCC meeting arranged by municipality quarterly(No. of Meeting)	28	24	85.71%
MESPCC members participated in the quarterly meeting. (No. of MESPCC Members)	567	415	73.19%
MHD Staff Attending Monthly Meetings (No. of MHD Staff)	84	56	66.67%
CHVs' trained by municipality health staff supported by MHPP (No. of CHVs)	3375	1721	50.99%
Imams trained supported by MHPP (No. of Imams)	505	164	32.48%
TOT for FWV(Family Welfare visitor) (No. of FWVs)	28	28	100%

b) Rapid Assessment Results

A rapid assessment was conducted in September 2006, however the results were not available in time for this report. They will be forwarded as soon as they become available.

F. SUSTAINABILITY

a) Sustainability Plan Overview

The Municipal Health Partnership Program model was designed with sustainability as a primary goal from its inception. As such the project is inherently sustainable from the financial perspective as all activities build on existing resources available from residents, private sector and the government. No additional compensation is provided to any Government partners or community members leading or participating in program activities. There are no direct inputs from Concern beyond facilitation, networking and coaching. Activities are not carried out without ensuring our primary partners (the Municipal Authority, its Department of Health, local NGOs or other stakeholders) take ownership in the activity.

b) Applying the CSSA Framework

To track and ensure sustainability of program inputs the CSSA framework has been employed. The specific measures taken to ensure sustainability under each component and a status update on each follows (see Annex # for complete list of indicators for all CSSA components).

Component 1: Health Status

Indicators: From KPC conducted at baseline, midterm and final evaluation
Status: Baseline KPC was conducted in preparation of the DIP in March 2005
Midterm KPC is planned for 2nd quarter of year 3 of the program
Sustainability Measures: The KPC will demonstrate the program's success in reducing harmful health and hygiene practices and creating new social norms which is evidence of sustainable behavior change (impact of BCC strategy).

Component 2: Quality and Access of Health Services

Indicators: Indicators will be selected from the new Rapid Health Facility Assessment (piloted at four facilities in MHPP program areas in September 2006) while ensuring the necessary data would be available from the results of the initial health facility assessment conducted pre-DIP, which will serve as the baseline for this component.
Status: The next set of data will be collected by the HFAs conducted as part of the Municipal Diagnosis every 6 months.
Sustainability Measures: Training of CBAs affiliated with the MCWC (Centers of Excellence) is being conducted by FWVs who are in turn trained by MoHFW. In DIP Year 3 MHPP will begin discussing sustainable quality improvement measures at the MCWCs with the MESPCC and MCWC managing doctors.

Component 3: Local Organizational Capacity

Indicators: From Municipal Authority Capacity Assessment (MACA) – formerly HICAP
Status: Baseline assessments conducted with all 7 Municipal Authorities.
Sustainability Measures:

As the Municipal Authority (local government) in each municipality is the program's primary partner, capacity building (training, awareness raising, improving management systems, advocacy to address gaps in the system, etc.) of the Municipal Authority (MA) and its Health Department (MHD) is at the heart of the program's health systems strengthening efforts (Objective 1) and its sustainability efforts . Therefore MAs and their MHDs are the targets of this component.

The MACA tool is a self-assessment and more importantly a planning tool designed to focus the MAs' attention on capacity building and system improvement measures by providing a practical, comprehensive way to approach these often daunting issues. The tool was revised based on lessons learned from its introduction in the predecessor program in Saidpur and Parbatipur

municipalities. The assessments were conducted via workshops facilitated by Concern staff with the Municipal Cabinet (including all Ward Commissioners) and Municipal Health Staff participating.

Challenge:
Convincing very busy Cabinet members to devote three days to the capacity assessment workshop, the concept and benefit of which was not immediately evident to them.
Solution: Concern's senior facilitators and project manager for each municipality delicately explained the benefits of the assessment through a series of meetings with the Municipal Chairmen and key cabinet members, to convince the cabinet to adopt the new tool. Five out of seven MAs agreed to have Concern facilitate a workshop for the initial self-assessment. To convince the remaining two MAs, the Concern senior facilitators along with a NY based consultant adjusted the workshop design to be completed in two days, while maintaining the appreciative inquiry method at the core of the MHPP approach.

Baseline Results:

Complete table of baseline assessment scores can be found in ANNEX C. Municipal Authority participants scored themselves on each indicator by selecting the stage of achievement they felt they belonged (stage 1 – just planting the seeds, stage 5 – fruit bearing). There are between 2 to 6 indicators per Capacity Area. Key findings are presented below:

- Overall average score for Organizational Capacity: 2.35 (stage 2 of 5)
  Lowest Scoring Capacity Area: Monitoring and Evaluation (Avg Score: 1.97)
  Highest Scoring Capacity Area: Municipal Authority Leadership (Avg. Score: 2.82)

- Overall average score for Organizational Viability: 2.57
  Lowest Scoring Capacity Area: Supportive Health Policy (Avg Score: 2.24)
  Highest Scoring Capacity Area: Continuity of Service (Avg. Score: 2.94)

Component 4: Local Organizational Viability

See component 3, as indicators for this component were introduced as part of same tool along with component 3 indicators and assessed together.

Component 5: Community Capacity

Indicators: From Ward Health Committee Capacity Assessment tool
Status: Redesigned tool field tested with two Ward Health Committees. Facilitator's Manual draft complete, awaiting reviewers' comments. Training of facilitators to begin DIP Year 3.
Sustainability Measures:

The purpose of the Ward Health Committee Capacity Assessment tool is to guide the WHCs in their quest to become an effectively functioning, well regarded institution within their communities by providing a practical approach to the daunting task of developing systems, procedures, accountability measures, etc. By maintaining focus on organizational development issues which are often put to the way side in an organization's daily tasks, this self-assessment

tool will ensure the WHCs are strong self- functioning sustainable institutions by the time Concern begins its withdrawal.

To further ensure the sustainability of the WHCs and the capacity building process, Concern is training the MHD representative on each WHC and two additional members voted by the WHC as facilitators of the self-assessment workshop and planning sessions.

Field Test Results:

WHC members provided valuable feedback on areas requiring further clarification and demonstrated the need for facilitators to actively promote every member's participation, especially those from disadvantaged groups or unable to read and write who tend to stay quiet. Most importantly members displayed interest and motivation as they poured over the tool to analyze it. Many expressed their belief that this will be a very valuable tool for the WHCs, including several comments made after the sessions away from the foreign consultant and lead facilitators, indicating a promising future for the tool.

Component 6: Enabling Environment

Indicators: Defined through participatory process with Concern staff and WHC members
Status: All indicators identified. Data source for two indicators is the WHC as representative of community (questions added as supplement to WHC Capacity Assessment), remaining five indicators can be obtained from KPC with minor changes/additions.
Sustainability Measures:

c) Final Words on Sustainability

The keys to the sustainability of any program are the transfer of skills and the establishment of effective systems. The majority of MHPP activities fall into one of these two categories.

In the training of CHVs, CBAs and PPs sustainability of continued training cycles is ensured as Concern is training the Municipal Health Staff, MCWC doctors and licensed private doctors as trainers of each of the said cadres respectively. Since high turn over exists among some of these trainers, MHPP has established a second layer of sustainability protection by involving leaders of three NSDP supported local NGOs Kanchan Samity, Tilottoma Voluntary Women's Organization and UPGMS-R. Members of these NGOs serve on WHCs, are included in TOTs to supplement MHD staff as trainers, attend MHD meetings, and the NGOs support WHCs with supplies and logistics in planning special events. The program's intention is for these NGOs to take over some or all of Concern's catalyst role once the program comes to an end.

The program is also continuously working to close gaps in the health system through advocacy and technical support to Municipal leaders and other stakeholders.

G. RESPONSE TO USAID QUESTIONS ON AR 2005

The following is in response to questions posed by Nazo Kureshy in her e-mail on

May 5, 2006.

a) What are the criteria for setting health facility benchmarks? Describe the variation in benchmarks across municipalities.

The primary goal of the health facility assessment conducted prior to writing of the DIP was to identify at least one facility in each municipality that would serve as a Center of Excellence for maternal and newborn care. Concern's NGO partner, LAMB conducted the assessment using tools developed by JHPIEGO's AMDD Project. LAMB's recommendations and supporting arguments for each facility assessed is included under ANNEX D. The variation among the facilities assessed on key indicators can also be seen in the summary results presented by LAMB in ANNEX D.

To ensure sustainability and contribute to the strengthening of Rajshahi Division's health system, it was decided to focus on government owned facilities. LAMB recommended five MCWCs and two district hospitals upon completion of the assessment, however in the national sharing meeting of the assessment findings it was determined that the intervention would be more successful if the project focused solely on the MCWCs with the advantage of working with a single line of management.

b) Is the project implementing a comprehensive HBLSS strategy or only updating the LAMB CBA curriculum to include LSS?

The revised CBA curriculum is not an LSS or HBLSS curriculum. It was developed by LAMB in line with national best practice and is now awaiting final approval by the MoHFW, which is expected shortly.

c) Provide an update on the establishment and activities of the Learning Centers.

The primary functions of the Saidpur and Parbatipur learning centers are listed in the box below. Each Learning Center has a Learning Center Coordination Committee (LCCC) headed by the Municipal Chairman of each municipality and comprised of select members of the MESPCC, select Commissioners (head of WHCs), the MHD Medical Officer (head of Dept.) and/or MHD Secretary. The LCCC meet quarterly to discuss ways they can support the scale-up municipalities and plan meetings for visitors. LCCCs often support MESPCCs and WHCs in new areas by sending guest speakers to their meetings.

Primary Functions of the Learning Centers:
➢ Host orientations for stakeholders in scale-up municipalities (Municipal Cabinet, MHS, Imams, CHVs, teachers, etc.) including visits with Municipal Chairmen, WHCs, CHVs, CBAs, MESPCC, etc. of LC municipalities (Saidpur and Parbatipur) ➢ Host CHV, CBA, Imam & Teacher, WHC, and MESPCC progress sharing meetings ➢ LC Concern staff continuously monitor and provide support to MAs, MHDs, MESPCCs, and WHCs of LC municipalities with health related and capacity building issues (support is

minimal compared with original CSP), including: Development of Municipal Annual Health Plans, HMIS implementation, refresher trainings, etc.

- Continued advocacy at municipal and district levels
- Host Inter-Municipality Behavior Change Team (IMBCT) meetings
- Host PP negotiation meetings
- Participate in post-assessment evaluations
- Supervise LQAS survey teams in new sites

Key achievements of the Learning Centers in this reporting year include:

- Successful advocacy to MoLGRDC to fill the posts of Municipal Medical Officer (head of MHD) in Saidpur and Parbatipur and recruitment of additional Municipal Health staff in Parbatipur

- Successful advocacy to Municipal Authorities to increase health budget

- LC Concern staff facilitated the second Municipal Authority Capacity Assessment (MACA, formerly HICAP) in Saidpur and Parbatipur (assessment conducted every two years, baseline assessment in 2004)

- In response to the poor functioning of several WHCs, an in-depth ward by ward analysis of all WHCs in Saidpur and Parbatipur municipalities and the factors impacting their progress was undertaken and based on the results a one year plan was developed to address the current issues.

d) Provide an update on the OR focusing on indoor air pollution

See Section A, part b, Objective II, item 9: *Operations Research: Indoor Air Pollution (IAP)*

e) Provide an update on CWI's assistance to the government with scaling up C-IMCI. What phase is piloting in? Are all pilot districts implementing C-IMCI?

See Section A, part a, item 4: *Concern conducting national pilot C-IMCI roll-out in nine municipalities (urban) and one upazilla (rural).*

f) Will 6 months allotted to OR be sufficient? How many emergencies will be assessed in this timeframe?

The OR this question refers to, *Impact of WHC Social and Financial Support in Maternal and Newborn Emergencies,* was not conducted in this reporting year as planned because it was felt that the WHCs, having just been formed, had not yet reached the stage of development that

would provide a true picture of their potential to impact maternal and newborn emergencies. The query will be included in the mid-term evaluation to be held in DIP Year 3.

H-K: SECTIONS NOT APPLICABLE TO THIS PROJECT

L. MANAGEMENT SYSTEM

a) Financial Management

Concern's regional office at Rangpur oversees and supports the Program's financial management with the technical input of the Regional Accounts Officer. The Project Managers are responsible for tracking project expenses and adjusting expenses with the Program Support Officer at the regional office needed. The regional office sends monthly financial reports to the Dhaka office, where the monthly program expenditure is compiled. Financial reports are forwarded on a quarterly basis to Concern Worldwide for submission to USAID Washington.

b) Human Resources

The project level activities are implemented under the management of the Northern Regional Program of Concern. The Program Manager is responsible for strategic and operational management of the program, maintaining budget requirements and requesting technical support from the Health and Nutrition technical team based in the Dhaka office. The Senior Advisor for Health and Nutrition of the Concern Dhaka Office provides technical support and guidance. The support team based at the regional office, consisting of Technical Managers for MNC and IMCI, Senior Project Manager (Operations), Learning and Documentation Manager, the Training Team and the Monitoring & Evaluation Team provide continuous technical support to the municipal based project team.

Project Managers for each municipality are responsible for leading the team and assigned activities at the municipal level. During the reporting period the senior Training officer Passed away (23 July 2006). He played a vital role to carry forward the training plan of the program. His death definitely would leave some impact on program outcome. The other members of the program are trying to minimize the gap.

c) Communication System and Team Development

Each of the Project team meet weekly and review their last week plan and set the priority for the next week and pass it to the respective line manager(Senior Project Manager). The support team based at Regional level also meet at the first day of the week and review their agenda for the last week and come up with agendas of next week after analysing the municipal response. The Project Management team(Program Manager, Senior Managers, Technical Managers, Project Managers) meet every month to review the progress and plan for the up coming month. The whole team(Support team and Project team along with Program Manager) at the municipal areas to review team performance, identify upcoming priorities and review the work-plan.

The program has developed its monitoring system based on the log frame indicators. This system is using to measure progress on most of the process indicators on a monthly basis. The Monitoring & Evaluation Team at the regional office and Dhaka collect data on program outputs and compare them with project work plans and indicators to measure progress. The program has conducted a rapid assessment using LQAS in seven municipalities. The data generated by the system is regularly shared with the partners and stakeholders for further action. Monthly reports are prepared and shared with the Dhaka Health and Nutrition team. Reports are also reviewed by the Health Advisor based at headquarters on during her semi annual visits.

d) Local Partner Relationships

As mentioned throughout the report, the status of local partnerships is excellent in terms of the municipal authorities, service providers including NSDP and other NGOs working in urban development.

e) PVO Coordination/Collaboration in Country

National Level:
During the reporting period PAC met once and discussed about the progress and operations study on IAP and cost effectiveness. The retaining of the municipal medical officers was also discussed. It was agreed in the meeting that we would disseminate the HFA report which was carried out last year and then the CoE would be finalized. Concern is closely working with the national IMCI working group headed by MOHFW where UNICEF, WHO, USAID, ICDDR'B, NSDP , PLAN are the members.

Project level:
The program is collaborating with Civil Surgeons and Deputy Directors of the Family Planning Department under MOHFW and health facilities at district and local level to ensure essential supplies and technical support to municipalities. It also collaborates with three NSDP-supported NGOs and other health NGOs and community based organizations to ensure increased support for the municipality and ward committees. A field testing of PP module was piloted in Dinajpur (4&5 August 2006) in coordination with partners.

f) Other Relevant Management Systems: N/A

M. MISSION COLLABORATION

Regular contact is maintained with the local USAID mission regarding program activities. A representative of the USAID Mission also serves on the PAC committee which serves as an advisory committee to the MHPP.

N. ANNUAL PLAN 2006-2007

See ANNEX F.

O. RESULTS HIGHLIGHTS

Promising Practice I: The Municipal Essential Services Packages Coordination Committee (MESPCC)

a) The Problem

The Ministry of Health and Family Welfare is not formally responsible for health within the Municipalities, beyond the district hospitals. The oversight of the Municipalities falls under the Ministry of Local Government, Rural Development and Cooperatives (MOLGRD&C), the Family Planning Division of which oversees the MCWCs but does not take responsibility for the overall health of municipal populations. The District Civil Surgeon's office of the MoHFW is to support the Municipal Health Department but this link has been weak and almost entirely focused on NIDs. Due to this gap health issues within municipalities have been a very low priority for the Municipal Authorities with little to no coordination between the efforts of the MoHFW, Municipal Authority and other actors involved in health.

b) The Project Input to Address Problem

The creation of an MESPCC like committee was first decreed by MOLGRD&C in 1995. However, it was on paper only until Concern started the original CSP in Saidpur and Parbatipur and starting 2004 in the seven scale-up municipalities. The MESPCC serves as the bridge connecting the major institutions involved in assuring the health of the Municipal population. The role of the now multisectoral MESPCCs (see Section A,a,1 for list of members) is to:

1. Coordinate all Municipality wide healthcare initiatives and communications campaigns.

2. Maximize utilization of resources.

3. Promote understanding between Government, NGOs and citizens on healthcare and health & hygiene behavior issues.

4. Provide a local advocacy platform allowing all sectors represented to advocate to each other on pertinent issues and potential solutions.

c) Magnitude of Intervention

Multisectoral MESPCC's have been established in nine municipalities (2 in original program, 7 as part of scale-up) serving a total population of 1,069,534.

d) Quantifiable Results

Evidence of Improved Coordination:

- MESPCCs coordinate joint health campaigns on issues such as Vitamin A Distribution, NIDs, etc. Previously the effort was lead by the Civil Surgeon's office and only for NIDs. The MESPCCs have now taken over this role resulting in far more comprehensive campaigns and on issues/services beyond NIDs.

- Even before the formal HMIS is implemented, some MESPCCs have taken the lead, establishing regular reporting at meetings on healthcare facility performance.

- MESPCCs provide a forum for advocacy efforts. To date they have been instrumental in efforts on use of MCWCs as CoEs and the increase in Municipal Budgets towards health.

- Perhaps the best indication of the success of the MESPCCs is that widely expected clashes between MESPCC members, many of whom hold political positions, have NOT happened by enlarge. Instead, face to face discussions between parties who would not meet otherwise has resulted in better understanding of the factors impacting the municipal health system for all involved. For example, at one MESPCC meeting where Ward Commissioners brought up their constituents complaints that certain health facilities were missing supplies, the Civil Surgeon was able to explain that supplies had not arrived from central warehouses.

Evidence of MESPCC Institutionalization:

- 100% of MESPCC meeting held within this reporting year.

- Several MESPCCs have selected up to three alternate leaders.

- After much advocacy by the MHPP team and Municipal Chairman Quarterly reports completed and submitted to MOLGRD&C.

- ALL MESPCCs have nominated one representative to Inter Municipality Behavior Change Team (IMBCT).

Promising Practice II: Role & Contribution of CoE in Improving MNC

a) The Problem

The problems being addressed are the low rate of skilled delivery, delivery at a health facility and underutilization of government owned health service delivery facilities especially the MCWCs (maternal and child welfare centres). According to the baseline KPC survey (2004), .in the MHPP working area, the rate of institutional delivery is 44%, 49% of deliveries are attended by a trained attendant at home or at a facility and 25% are attended by untrained TBAs (now known as CBAs).

b) The Project Input to Address Problem

The MHPP model involved the selection of a cadre of health facilities which would receive technical support from Concern and its partners, including key Government ministries to become a Center of Excellence (CoE) providing maternal and newborn care meeting international standards within Bangladesh national policy. A key feature of the model is the building of a strong linkage between the CoE and the community by having the CoEs serve as a training site for CBA trainings/meetings and through the active involvement of MCWC staff in community health initiatives. It is hoped this will lead to significant increase in utilization of services and health facility based deliveries. Sustainability of the model is ensured as all

trainings are provided by government staff and establishment of quality improvement system at the MCWCs.

As the municipality anchor for maternal and newborn care, the CoEs are expected to have the following functions:

- Ensure state of art best practices in ANC, Delivery, PNC, immediate breastfeeding and child health services.
- Organize and conduct CBAs training in birth preparedness, promoting ANC, the conduct of clean home deliveries (when delivery at a facility is not possible or preferred), essential newborn care, promotion of immediate breastfeeding, recognition of complications, and when to make timely referrals.
- Support Municipal health department in organizing and conducting monthly refresher training and meeting of the trained CBAs inside the facility premises.
- Provide supportive supervision to the trained CBAs.
- Ensure quality of care and client friendly environment in the facility;
- Arrange workshops at regular interval on quality improvement of the Health Facilities.
- Maintain informative records of referral from CBAs and other service providers and to other health facilities.

The MCWCs were selected as CoEs after a comprehensive HFA conducted by MHPP partner LAMB and a national sharing meeting involving key government officials. To ensure the successful transformation of MCWCS into CoEs the MHPP has taken a number of key steps as follows:

- A series of formal and informal interactions with MoHFW and MoLGRD&C, Department of Family Planning, personnel at the national, divisional and local level.
- The MESPCCs were successfully used as the forum to advocate for MCWC as CoE model
- The Offices of the Directorate General of Health (MoHFW) and Directorate General of Family Planning (FP) were properly sensitized and involved in all aspects of the process (HFA, development and approval of training modules, invited to visit trainings,etc.)

c) Magnitude of Intervention

- 7 MCWCs will serve as CoEs (one per municipality) covering the entire MHPP area with 225,122 women of reproductive age and 94,377 children under five
- 71% (10 out of 14) MCWC doctors received MOET training
- 36% (5 out of14) received PNDA training.
- 100% (28) of FWVs received TOT on CBA training
- MCWC Quality Improvement measures and training of 325 CBAs to begin DIP Year 3

d) Quantifiable Results

- Directorate General of Health (MoHFW) and Directorate General of Family Planning (FP) offices have demonstrated strong support for the model by giving an official government order and accepting invitations to visit MCWC doctor and FWV trainings. Almost all district level officials have visited at least one training.

- Although it can be seen as an extra burden for the often understaffed MCWCs, all managing doctors agreed to allow MCWCs as site of CBA training and for trainings to be conducted by FWVs and are now eager to begin.

- MCWC managers are actively supporting MHPP activities (attending MESPCC meetings in Bogra, participating in Municipal Annual Review process in Kurigram, participating in WHC organized health fair in Joypurhat, attending WHC events and special day observances (i.e. Breastfeeding Week). At a number of such forums they have raised their voice to show support for the MHPP model and commitment to supporting its initiatives.

- WHCs are already reporting that their CHVs have begun commenting on the improved attitude of MCWC staff towards patients they refer. A formal tracking system will be put in place once CBAs are trained.

P. SECTION NOT APPLICABLE

Q. OTHER

a) Status of Operations Manual

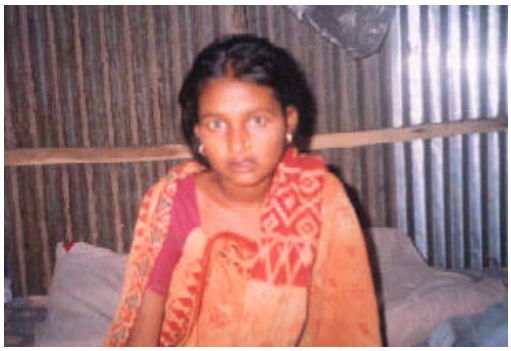
Per USAID's request, Concern is preparing an Operations Manual documenting in detail the implementation process of its Child Survival program in Bangladesh, including the original CSP project and how it has lead to the MHPP extension. The MHPP Learning and Documentation Manager and Concern's Child Survival Technical Support consultant, who will be writing the Manual, have inventoried all existing documents to be used as resources. The content and overall structure of the Manual has been finalized with input from the MHPP team, MHPP Program Manager, Concern Bangladesh Health and Nutrition Director and Concern US Health Advisor. As the Manual is to capture MHPPs entire implementation, the writing of the Manual will be completed in parts. The consultant has conducted a series of interviews for the initial portions of the Manual. The first section of the Manual will be ready by December 2006.

R. PUBLISHED PAPERS AND/OR CONFERENCE PRESENTATIONS

An article featuring the Indoor Air Pollution study, entitled "Reducing Smoke, Improving Child Healht" was published in The Health Exchange (Magazine of the RedR-IHE, based in London), May 2006 issue (see ANNEX E). The MHPP Program Manager will be presenting a paper on *Strengthening Ward Health Committees* in Urban Bangladesh at the APHA annual conference on Nov. 4-8, 2006 in Boston, MA as part of a panel on *Community Approaches to Improving Health: Four Success Stories* and leading a discussion on *Successful Community Public-Private Partnerships to Reduce Maternal and Child Mortality* as part of a workshop at the Conference.

ANNEX A. WHC CASE STUDY

Saving Lives: Shahina's Story



Shahina was only 17, lived Chayani para, ward 5 of Kurigram municipality. Though her age was beyond country's marriage law she was a mother of one child moreover became pregnant again for 8 months. Poverty, less awareness as well as family's delayed decisions forced her life expired. It's a very common story of Bangladesh. But WHC's initiatives saving her life as well as community's awareness after the incident is exceptional. Let us look at a glance over the whole picture.

Shahina's day labourer husband Mohammad Lalu didn't get job regularly. While meeting three meals was quite difficult, regular medical check up for pregnant Shahina, who was also suffering from heart diseases, got no importance at all. Shahina herself didn't have any courage to raise treatment issue in the family. Since her first child was delivered at home, same thing would be followed for the second one was decided by her husband & mother-in –law. Neighbours knew the situation but they had no idea what to do for the poor fellow.

Last 15 February a monthly meeting of Ward Health Committee (WHC)- a community level forum was held. On that meeting Tahmina and Mahinoor - two members of the forum raised Shahina's issue and appealed for helping the distress teenage mother. WHC didn't has any fund to meet such cases at that time. Just after two days Shaina's condition deteriorated, required immediate hospitalization. Tahmina and Mahinoor came forward to help her. But they failed getting her family members consent. As a second chance they mobilized a group of community people in order to making Shahina's family assertive. They succeed and took Shahina to nearby Maternal & Child Welfare Centre (MCWC). Ward commissioner and the WHC members brought her to sadar(district level) hospital at 12 am as MCWC's doctor suggested. At 3 am her condition worsened but there was no duty doctor. So they again brought her to a near by clinic. Seeing her critical condition clinic doctor refused to admit her saying this patient is out of their capacity. WHC members and others tried to get a favour from him through narrating all the initiatives they had taken from 10 pm. She got admission on that clinic and an immature child was born at dawn.

Next morning Concern MHPP Kurigram team visited the clinic. And they discussed with Shahina's doctor what MHPP is doing for saving mother as well as child's life. They also highlighted how WHC is working for them. Municipal chairman also met the clinic proprietor and other staff saying them not to worry about money while serving to Shahina. He also requested WHC for preparing a vulnerable mother's list because of addressing their regular check-up and treatment.

After one day of birth Shahina's child died. But she was coming round. Chairman & WHC members bear 7 thousand taka, the total money for her clinic charge, medicine and food. For her heart diseases treatment she again was admitted to sadar hospital and spent a week there.

Chairman, commissioner and WHC members did a lot for a neglected poor mother like Shahina, became prime discussion issue at the community. Therefore WHC decided sharing their experience to the community. With the help of Paribarik Swastha Clinic WHC arranged a mass gathering where nearly 400 people attended for awareness building on health. On that meeting they screened enter-educate drama on health 'Anechi Surjer Hasi'. Songs and discussion session was also included on that program. Municipal panel chairman, WHC members, clinic manager of Paribarik Swastha Clinic and other staff members, international NGO Care's representative, Concern Kurigram team also presented on that program.

After that gathering community's reaction was we can fight against any obstacles of health like Shahina if you (WHC & others) stand by us. Shahina expired after the mass gathering. But her death become a lessons learned for the WHC and community.

ANNEX B: List of CSSA Indicators

Component #	Capacity Area/Indicator
Comp 3	**Organizational Capacity**
I	**Human Resources Supervision and Development**
I-1	MHD Posts Filled
I-2	Supervision, Roles and Responsibilities of MHD Staff
I-3	CHV and TBA Qualification
I-4	CHV and TBA Capacity Building
I-5	Proper Supervision & Appraisal Process for CHVs and TBAs
II	**Municipal Authority Leadership**
II-1	Cabinet Members' Motivation, Vision and Action
II-2	Cabinet members' sense of responsibility on health issues and decision making process
II-3	Second Line Leadership
II-4	Participation of Women Leaders
III	**Planning and Implementation**
III-1	MHD Activity Plans
III-2	Regular MHD Meetings
III-3	Accomplishing Activities
IV	**External Coordination and Local Resource Mobilization**
IV-1	Resource Management
IV-2	Communication and Coordination with Relevant Individuals and Institutions
IV-3	MESPCC Participation
V	**Monitoring and Evaluation**
V-1	M&E Staff
V-2	Data Collection and Preservation
V-3	Data Analysis and Information Dissemination
V-4	M&E Data Informs Decisions
V-5	Quality Assurance System
Comp 4	**Organizational Viability**
I	**Trust Among Partners**
I-1	Politically Biased MHPP Approach
I-2	Trust Between Formal Service Providers and Cabinet
II	**Continuity of Service**
II-1	Reliability of Essential Drugs and Supplies for EPI and Vitamin A
II-2	Budget Allocation for Health Activities
II-3	Budget Allocation for Staff Salaries
II-4	Spirit of Volunteerism
II-5	Attendance at Volunteer Meetings
II-6	Enthusiasm of WHC Members
III	**Supportive Health Policy**
III-1	Linkage Between Civil Surgeon and MHD
III-2	Dedicated National Funds to Health
III-3	Urban Health Policy Development Process
IV	**Political Accountability of Commissioners**
IV-1	Commissioners' Perception of the Importance of Health on Re-election

ANNEX B: List of CSSA Indicators

IV-2	Committee Members' Perception of Commissioner's Dedication
IV-3	Municipal Authority's perception of the community's perception of WHCs
IV-4	Communities' Satisfaction
Comp 5	**Ward Health Committee Capacity Assessment**
I	**Participatory Planning**
I-1	Meeting Attendance
I-2	Regular Meetings with an Agenda
I-3	Written Annual Plan
II	**Leadership (Governance)**
II-1	Membership Replacement Process
II-2	Secondary leader and other committee roles detailed in writing, assigned and understood
II-3	Participatory Decision Making
II-4	Community Perception of WHC
III	**Resource Mobilization and Management**
III-1	Fundraising in Annual Plan
III-2	Financial Documentation and Transparency
III-3	Resource Mobilization and Utilization
III-4	WHC Office, Bank Account, Seal and Pad
IV	**Collaboration and Coordination**
IV-1	Collaboration and Coordination with other WHCs
IV-2	Collaboration and Coordination with Health Service Providing Institutions
IV-3	WHC Support to CHVs and TBAs
IV-4	Collaboration with Other Institutions
V	**Monitoring and Evaluation**
V-1	Review of Annual Plan
V-2	Annual review Results are Considered during Future Planning
V-3	Support and Use of HMIS
Comp 6	**Enabling Environment (socio-ecological situation)**
I	Impact of Natural Disasters (WHC)
II	Environmental Sanitation (KPC)
III	Emergency Financial Support for the Poor (KPC)
IV	Political Freedom (WHC)
V	Primary Education Attainment of Women (KPC)
VI	Poverty (KPC - asset quintiles)
VII	Gender Discrimination (KPC)

ANNEX C: Municipal Authority Capacity and Viability Assessment Scores

Component #	Capacity Area/Indicator	Nilphamari	Kurigram	Ghailbandha	Dinajpur	Rangpur	Bogra	Joypurhat	Overall Avg
Comp 3	**Organizational Capacity**	**1.57**	**1.92**	**1.66**	**2.16**	**2.84**	**2.99**	**3.34**	**2.35**
I	**Human Resources Supervision and Development**	**1.00**	**2.20**	**1.60**	**1.20**	**2.00**	**2.60**	**3.20**	**1.97**
I-1	MHD Posts Filled	1.00	2.00	2.00	1.00	3.00	2.00	3.00	2.00
I-2	Supervision, Roles and Responsibilities of MHD Staff	1.00	3.00	2.00	2.00	3.00	2.00	3.00	2.29
I-3	CHV and TBA Qualification	1.00	2.00	2.00	1.00		3.00	4.00	2.17
I-4	CHV and TBA Capacity Building	1.00	2.00	1.00	1.00	1.00	4.00	3.00	1.86
I-5	Proper Supervision & Appraisal Process for CHVs and TBAs	1.00	2.00	1.00	1.00	1.00	2.00	3.00	1.57
II	**Municipal Authority Leadership**	**2.00**	**2.00**	**1.75**	**2.75**	**4.00**	**3.75**	**3.50**	**2.82**
II-1	Cabinet Members' Motivation, Vision and Action	2.00	3.00	2.00	2.00	3.00	4.00	4.00	2.86
II-2	Cabinet members' sense of responsibility on health issues and decision making process	2.00	3.00	3.00	2.00	4.00	3.00	4.00	3.00
II-3	Second Line Leadership	2.00	1.00	1.00	3.00	5.00	5.00	3.00	2.86
II-4	Participation of Women Leaders	2.00	1.00	1.00	4.00	4.00	3.00	3.00	2.57
III	**Planning and Implementation**	**2.00**	**1.67**	**1.00**	**2.00**	**2.00**	**3.67**	**3.67**	**2.29**
III-1	MHD Activity Plans	2.00	1.00	1.00	2.00	2.00	3.00	3.00	2.00
III-2	Regular MHD Meetings	2.00	2.00	1.00	3.00	3.00	4.00	4.00	2.71
III-3	Accomplishing Activities	2.00	2.00	1.00	1.00	1.00	4.00	4.00	2.14
IV	**External Coordination and Local Resource Mobilization**	**1.67**	**2.33**	**2.33**	**2.67**	**4.00**	**3.33**	**3.33**	**2.81**
IV-1	Resource Management	2.00	2.00	2.00	2.00	4.00	2.00	3.00	2.43
IV-2	Communication and Coordination with Relevant Individuals and Institutions	2.00	3.00	3.00	2.00	4.00	4.00	4.00	3.14
IV-3	MESPCC Participation	1.00	2.00	2.00	4.00	4.00	4.00	3.00	2.86
V	**Monitoring and Evaluation**	**1.20**	**1.40**	**1.60**	**2.20**	**2.20**	**1.60**	**3.00**	**1.89**
V-1	M&E Staff	1.00	1.00	2.00	2.00	2.00	1.00	3.00	1.71
V-2	Data Collection and Preservation	1.00	1.00	1.00	2.00	1.00	1.00	3.00	1.43
V-3	Data Analysis and Information Dissemination	1.00	2.00	2.00	3.00	3.00	2.00	3.00	2.29

ANNEX C: Municipal Authority Capacity and Viability Assessment Scores

V-4	M&E Data Informs Decisions	1.00	1.00	2.00	2.00	3.00	2.00	4.00	2.14
V-5	Quality Assurance System	2.00	2.00	1.00	2.00	2.00	2.00	2.00	1.86
		Nilphamari	**Kurigram**	**Ghailbandha**	**Dinajpur**	**Rangpur**	**Bogra**	**Joypurhat**	
Comp 4	**Organizational Viability**	**2.25**	**2.25**	**2.46**	**2.68**	**2.44**	**2.73**	**3.19**	**2.57**
I	**Trust Among Partners**	**2.50**	**2.00**	**2.50**	**2.00**	**2.00**	**2.00**	**3.50**	**2.36**
I-1	Politically Biased MHPP Approach	3.00	2.00	3.00	1.00	2.00	3.00	4.00	2.57
I-2	Trust Between Formal Service Providers and Cabinet	2.00	2.00	2.00	3.00	2.00	1.00	3.00	2.14
II	**Continuity of Service**	**1.83**	**3.00**	**2.83**	**3.40**	**2.33**	**3.33**	**3.83**	**2.94**
II-1	Reliability of Essential Drugs and Supplies for EPI and Vitamin A	2.00	5.00	3.00	5.00	4.00	4.00	4.00	3.86
II-2	Budget Allocation for Health Activities	2.00	4.00	2.00	2.00	3.00	2.00	3.00	2.57
II-3	Budget Allocation for Staff Salaries	2.00	5.00	3.00	4.00	4.00	4.00	4.00	3.71
II-4	Spirit of Volunteerism	1.00	1.00	2.00		1.00	3.00	4.00	2.00
II-5	Attendance at Volunteer Meetings	1.00	1.00	5.00	4.00	1.00	4.00	4.00	2.86
II-6	Enthusiasm of WHC Members	3.00	2.00	2.00	2.00	1.00	3.00	4.00	2.43
III	**Supportive Health Policy**	**1.67**	**2.00**	**2.00**	**2.33**	**2.67**	**2.33**	**2.67**	**2.24**
III-1	Linkage Between Civil Surgeon and MHD	2.00	3.00	2.00	2.00	2.00	2.00	4.00	2.43
III-2	Dedicated National Funds to Health	1.00	2.00	2.00	2.00	3.00	2.00	2.00	2.00
III-3	Urban Health Policy Development Process	2.00	1.00	2.00	3.00	3.00	3.00	2.00	2.29
IV	**Political Accountability of Commissioners**	**3.00**	**2.00**	**2.50**	**3.00**	**2.75**	**3.25**	**2.75**	**2.75**
IV-1	Commissioners' Perception of the Importance of Health on Re-election	3.00	2.00	3.00	4.00	4.00	4.00	3.00	3.29
IV-2	Committee Members' Perception of Commissioner's Dedication	3.00	3.00	3.00	3.00	2.00	4.00	4.00	3.14
IV-3	Municipal Authority's perception of the community's perception of WHCs	3.00	1.00	2.00	2.00	1.00	1.00	2.00	1.71
IV-4	Communities' Satisfaction	3.00	2.00	2.00	3.00	4.00	4.00	2.00	2.86

ANNEX D: Initial Health Facility Assessment Results

Appendix C-1 FACILITY ASSESSMENT SUMMARY SHEET

MUNICIPALITY: Bogra FACILITY: Md. Ali Hospital

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/records** • **Referral** • **Poor patients**	Currently 21 OB/GYN bed- will be 50 Total deliveries in 2004- 1816 Jan '05: Obstructed labor- 25; Eclampsia 9; retained placenta 24 Have copies of partogram- in Madam's office Have own ambulance Free hospital- but often have to buy meds, etc	Female patient load- 100+- need more space/ beds; C-sections= 561 (31%)- quite high Vacuum/forceps/dest = 32 Appropriate use of Vacuum extraction could lower the C/S rate Partogram not used- doctors make notes on patient 'ticket'- nurses don't seem to do regular observations in labor	Improve community awareness of value of skilled attendance at birth. Improve referral links from TBA's, Union Health Centers and MCWC Refresher training on Ventouse delivery for doctors and ?EOC trained midwives Separate area for general female patients
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	Dept Head- assist prof, FCPS Prof of OB/GYN- 2 OB/GYN consultant-2 (DGO, MCPS) Assistant registrar-2 Anesthesia dept. helps with anesthesia 16 senior nurses- 2 with EOC trng.	This is currently clinical area for medical students- therefore medical students/ interns do much of the patient assessment	EOC training for all nurse midwives working in Labor and Delivery- including practical training on use of partogram
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	Neonatal deaths- 3 (sick babies go to peds unit- so actual figures not available for this assessment)	Mat. Death 51 = 3185/1,00,000 live births Stillbirths 261 = 144/1000 total births Both are high- need death audit to determine areas for improvement in patient care	Verbal Autopsies on all Maternal Deaths to determine avoidable factors; points for potential intervention by Poroushova Perinatal Death Audit on SB's and NND's
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	Midwives and students on duty 24 hours Junior doctors on duty 24 hours- Senior consultants on-call Anesthesia department separate- on-call for C-sections Hospital blood bank + Sondhani	Although blood is available from two sources there is often a delay in actually getting blood in time for patients- blood sets are often not available	Blood bank and typing and cross-matching should be available 24 hours. Community awareness through Poroushova on value of giving blood.
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	Head of department; Senior nurse midwives trained and confident in doing neonatal resusc. Babies kept with mothers- breast fed Cord tied with purchased clamp or sterile cotton Have antibiotic ointment for eye care in OT	No blankets for wrapping NB in L&D: rely on cloth that pts bring; no heat source in L&D No separate post-partum ward/ partitions for delivery patients ? antibiotic eye oint.used for normal deliveries	Keep stock of re-useable flannel blankets for drying babies post-partum or educate families to bring warm cloth Train select staff in Kangaroo Mother Care for LBW newborns
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	L&D is moderately clean- ayah present and seemed attentive; chlorine/savlon to disinfect Gauze and glove autoclaved in drum Have vacuum extractor machine- kept in Head of Department's office. Oxygen available- nasal catheter re-used Antibiotic inj; oxytocic; sedative; Dextrose and NS; IV sets; some cannulas available	Three delivery beds in one room- no provision for privacy during examination/ delivery Stethescope and BP cuff shared with ward Only 2 delivery sets (minimum instruments)- boiled between cases- inadequate for case load of 4-5 deliveries/day Patients have to buy MgSO4; other supplies depending on govt. supply Adult and Neonatal ambu bags kept in OT	Two screens/ curtains on wire to separate delivery beds Stock of basic EmOC and emergency medicines and supplies available at all times for poor patients and emergency patients Separate adult and neonatal ambu bags for L&D
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT quite clean 2 C-section sets- boil if necessary Have suction/ oxygen- tubing reused Have basic emergency meds, some IV's Have Adult and neonatal ambu bags and mask Adult and NB laryngoscope, blades and ET tubes	Some meds are out of date- supply varies Medicines and resuscitation equipment kept locked in OT store- ? available after hours	Have C/S 'boxes' ready with all essential supplies (IV, cannula, IV set, meds, sutures, etc) for emergencies and poor patients. If supplies are limited those who can afford it can pay for the set so it can be replaced.
Overall impressions	A busy unit with a lot of manpower- potential to help a lot of women and babies.	Too many mothers and babies die here- more assessment is needed to determine avoidable factors/delays in community and hospital	

ANNEX D: Initial Health Facility Assessment Results

Appendix C-2, FACILITY ASSESSMENT SUMMARY SHEET

MUNICIPALITY: Bogra FACILITY: MCWC

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Mgmt. of labor/records** • **Referral** • **Poor patients**	10 beds; 2 labor and delivery beds Total deliveries 1403 in 2004 Complications: 31 pph; 24 ret. placenta; 16 prolonged labor; 24 PET; 13 cx tear Have own ambulance- referred 12 pt. to other hospitals in 2004; patients referred by TBA's are less sick than before Free service- most meds and supplies avail.	288 C-S- 20.5% - high for level of complications 509 episiotomies (36%) – decrease to 10% Syntocinon augmentation -625 (45%)- high Cause of so many cervical tears? Vacuum deliveries not done- proper use of Vacuum could decrease C-section rate. Partogram not used- FWV's do observations every 1/2hr- 1hr in labor	Consider upgrading to 20 bed MCWC with appropriate increase in staff, including 2 doctors able to do complicated cases/ C-sections. ?All doctors trained to do spinal Investigate reasons behind improvement in referrals- plan interventions accordingly Practical training on vacuum delivery for OB doctor(s), ? Sr. FWV
Staff: • **Staffing** • **Staff qualifications** • **EmOC / ENC training/skill**	MO-Clinic- MBBS, 1 yr EOC training MOMCH- 1 year anesthesia training 6 FWV's- 5 with 6 mo EOC training		Consider giving male doctor training in IMCI/ sick newborn care
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	No maternal deaths 30 Stillbirths- 21/1000 total births No neonatal deaths	Sick patients referred to Md. Ali Hospital	
24 hour EmOC service: • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	FWV's on duty 24 hours OB and anesthesia doctor live in quarters and are on-call after office hours 27 units of blood given in 2004	Two doctors cannot provide 24 hr EmOC service 365 days/ year Blood has to be purchased from outside- takes around 1 hour to bring- too long for APH/PPH cases; pathology not available at MCWC	Pathologist and equipment for blood typing and cross-match- for walking blood bank. Community education through ward health committees on importance of donating blood.
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	Medical officer trained and confident in doing neonatal resusc- FWV's assist Have tilt neonatal resusc bed in L&D with lamp Babies kept with mothers- breast fed Plastic sterile cord clamps used	No blankets for wrapping NB in L&D: rely on cloth that pts bring	Keep stock of re-useable flannel blankets for drying babies post-partum or educate families to bring warm cloth Train select staff in Kangaroo Mother Care for LBW newborns
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	L&D clean; instruments autoclaved; separate box for sharps One bed is slightly broken- but staff have managed to make it serviceable Have BP cuff; stethescope; oxygen; baby; scale; vacuum machine; bulb and machine suction Basic meds and supplies available	Currently no partitions available between beds- but they have plans Only 2 delivery sets- insufficient for number of deliveries (average nearly 4/day) Adult and neonatal ambu is in OT	The baby resuscitation bed with heat lamp is a simple but effective design- could be copied for other centers Optimum number of delivery sets-6. Separate adult and neonatal ambu bags for L&D
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT clean; instruments, gauze/gowns autoclaved OT table; trolleys; oxygen; suction machine; anesthesia machine; BP cuff & steth available. 2 full sets of C/S instrument (can make up to 2 more with extra instruments); 1 D&C set Emergency meds, IV's & supplies available Adult and NB ambu and masks, laryngoscope with blades available	Neonatal airways not seen- important for resuscitation	Supply of size 0 and 1 neonatal airways
Overall impressions	Well running clinic with good supply of drugs and equipment.	Less use of syntocinon for augmentation of labor, fewer episiotomies, selective use of vacuum for deliveries and use of partogram to monitor labor could further improve services	Increasing beds and staff could make skilled birth attendance and EmOC services available to many more women in the municipality

ANNEX D: Initial Health Facility Assessment Results

Appendix C-3 FACILITY ASSESSMENT SUMMARY SHEET

MUNICIPALITY: Bogra FACILITY: Bogra Mission Hospital

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referrals** • **Poor patients**	Obstetric beds: 22 Gyn beds: 4-5 Bed labor ward; 1 bed delivery room; a total of 29-30 beds. Total deliveries= 836 in 2004 Have large poor fund for eye patients- did not ask about provision for poor delivery patients Normally fee-for-service.	481 C-sections (57.5%)- very high, especially when most women who deliver there have ANC (14,0049 ANC/PNC visits in 2004); the patients come at the last time after being tried by the unskilled TBAs, self-choice by the patients. Vacuum deliveries not done- appropriate use of vacuum could help reduce high C/S rate Partogram not used: nurses record observations hourly in a khata	Chart audit would be useful to look at indications for C/S and appropriateness Purchase vacuum extractor and give drs practical training on appropriate use Work with ward health comm./ mission staff to explore ways of discouraging 'dalals' and increasing access for poor pt.
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	Head of Department, MBBS, DGO 1 MO, 1 DGO- another M.O doing DGO 2 junior doctors 12 nurse midwives-trained	No nurses have EOC training but getting on-job support, training in partogram beyond basic training. Have separate nursery for newborns- to decrease exposure to visitor germs-	All midwives/ doctors trained in use of partogram- have partograms printed
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	1-3/ maternal deaths/ 5 year (no stats seen) no perinatal statistics available	Records on delivery complications and maternal and perinatal outcomes not available	Death audit on all maternal and perinatal deaths- looking for avoidable factors in community and hospital
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	Midwives on duty 24 hours OB doctors take call for emergencies- both live in hospital housing Can do typing and cross matching Have own generator for electric supply	No resident/ staff anesthetist. Have to call from outside- can come in ½ hour. Charges Tk 600/ case No blood bank- staff go get blood for patients- available within ½ hour.	Train OB doctors or junior doctors to do spinal/ ketamine anesthesia and monitor patients during surgery. (Emergency Eteher is available.
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	DGO doctor and ward nurse in charge trained and confident in neonatal resusc Have neonatal resusc bed in L&D with lamp Cord tied with sterile thread	Baby friendly hospital- but sometimes give formula or spoon-fed when necessary Have separate nursery for visiting hours/ sick newborns	Need refresher on breast feeding
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	Labor room and delivery room clean Delivery sets autoclaved in tray- 6 sets Have fridge; warming lamp for baby; scale; suction; oxygen; BP cuff; steth; fetoscope Well supplied with emergency drugs; IV's, cannulas, giving sets; gloves; cloth; sutures Neonatal ambu bag and mask in delivery rm	No partitions in Labor room, but delivery room private. Have to move from labor room to delivery room for second stage Adult ambu bag kept in OT	Best to have adult and newborn ambu bags for both delivery room and OT.
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT clean; system for autoclaving instruments adequate; 2 sets of C/S instruments Radiant warmer; anesthesia; BP cuff; steth; suction machine Well supplied with gauze; gloves; suture; IV's and supplies; Adult ambu bag and mask, laryngoscope, blades and ET tubes available	Sometimes need to boil C/S instruments if there isn't time to autoclave Pt needs to buy foley catheter Neonatal ambu bag kept in delivery room- brought to OT for C/S No newborn laryngoscope	Purchase another set of C/S instruments so that all operations are done with autoclaved instruments
Overall impressions	Hospital clean and well equipped. Most emergency supplies available. Caring staff	Could benefit from updating in current best practice in some areas- eg use of partograph, rooming in; indications for C-sections	Giving a good service to their clients- but have high C/S rate for level of complications seen.

ANNEX D: Initial Health Facility Assessment Results

Appendix C-4: FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Dinajpur FACILITY: District Hospital

TOPIC	STRENGTHS	AREA FOR IMPROVMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/records** • **Referral** • **Poor patients**	46 OB/GYN beds 1909 total deliveries; 711 C-sections (37%) All complications managed – patients don't have to be referred on. 96 Eclampsia pt in 2004 Treatment is free	10 Vacuum/forceps deliveries- proper use of vacuum extraction could decrease the C/S rate Monitoring of labor patients by nurses recorded infrequently; No use of partogram Eclampsia/ emergency patient room farthest from nursing duty room- no separate staff Poor often cannot pay for medicines/supplies	Need more beds- separate areas for post-partum/ c-section patients, if possible. Could be done with screens if ward space not available. Sick patients/ labor patients need regular monitoring with observations recorded Partograph training for nurses/ doctors
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	4 Gynae consultant/professors (FCPS) 1 female assistant registrar 1 female MO 9 staff nurse- 1 has 4 week safe delivery trng from OGSB; 2 have 6 day training on ENC; 1 has PNDA and BF	No nurses have EOC training. Major skills absent in some nursing staff: partogram; cord prolapse; adult resusc; shoulder dystocia	EOC training for all nurse-midwives working in female ward
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	NND low- but sick newborns go to peds- therefore unable to assess actual perinatal mortality	32 maternal deaths/ 1735 live births= 1844/1,00,000 LB. In 2003 26 maternal deaths: eclampsia 10; ruptured uterus 7; PPH 6; abortion 3 Stillbirth rate: 92/1000 total births	Verbal Autopsies on all Maternal Deaths to determine avoidable factors; points for potential intervention by Poroushova Perinatal Death Audit on SB's and NND's TBA/ ? SBA training to improve safe home deliveries and early referral.
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	Nurse midwives available 24 hours Registrar/MO on-site 24 hours with back-up by on-call professor- can come in 10-15 min Three anesthetists rotate on-call Have own blood bank- can type and cross match blood and screen for HIV; Hepatitis B	Blood is not always available in blood bank. Relatives unwilling to give blood- have to purchase from outside. Price prohibitive (3-500 taka) for poor patients	EOC training for all nurse- midwives Poroushova health staff/ ward committees to do community awareness raising on value of blood donation; danger signs and referral
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	OB doctor and Sr. NM received training and are confident in neonatal resuscitation. Baby stays with mother Sterile cord clamp used- pt. buys	Female ward overcrowded, no partitions between beds- increase chance of NB infection No baby blankets/ heat lamp- use whatever cloths families bring- no area for baby resuscitation. No eye ointment for newborns stocked	Need separate trolly/ bed in L&D for baby resuscitation
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	Instruments autoclaved in OT. If needed quickly they are boiled by nurses	Labor and delivery room and female ward needs attention to cleanliness Three bedded L&D- also used for gynae patient assessment- screens would improve privacy. Medical students see pt with the professors- as it is a teaching hospital Delivery beds need some repair Neonatal and adult ambu bag available but need to be kept where immediately available for emergency. There is some scarcity of essential medicines	Mgmt. structures/motivation needed to ensure that limited supplies/equipment are used efficiently and properly maintained; cleanliness and patient privacy ensured. Increase in number of sweepers essential. Privacy is always an issue where there are many students. Improve supply of essential equipment: including working vacuum extractor and resuscitation equipment.

Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT area moderately clean Most instruments available- autoclaved and ready in drums Have anesthesia equipment- some meds	Some equipment shared between OT's- suction machine for mother/baby Emergency medicines; IV solutions, sets, cannulas; syringes; gloves; chlorine; antibiotics not always available	
Overall impressions	Adequate consultancy and nursing staff (with students). Registrar competent and hard working.	The female ward and L&D would benefit from more housekeeping input and prevision of supplies. Nursing staff , who manage labor patients, lack EOC training.	Increased motivation/ teamwork at all levels could help improve services. EOC training for nurses needed.

ANNEX D: Initial Health Facility Assessment Results

Appendix C-5 FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Dinajpur FACILITY: MCWC

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referrals** • **Poor patients**	10 bed- moderately full; 2 L&D beds Total deliveries in 2004: 653 C/S 149 Have own ambulance for referring emergency patients Free service- patients rarely have to buy medicines/ supplies	Only 9 beds d/t lack of space Low utilization for services available. C/S rate is 23%- high for level of complications managed Vacuum deliveries / MVA not done Some complications managed- but most referred to District Hospital	Improve community awareness of facilities/ services available Limit outside/private practice of medical staff EOC or DGO training for MO-Clinic
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	MO- Clinic- MBBS, MPH MOMCH- 1 yr anesthesia training 5 FWV's- 4 with EOC training	Only one FWV on duty day of visit- had also worked night. Others on deputation/ training. MO-Clinic doesn't use vacuum extractor	? increase beds/ staffing Posting of temporary staff when FWV/doctor is on training Vacuum delivery training for doctor (s)
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	No maternal deaths in 2004 SB+IUFD: 28/ 653 total births = 43/1000 total births Only 1 neonatal death	Complicated cases referred on due to lack of back-up for medical staff, which makes outcome stats look good.	Train TBA's/ SBA's in safe delivery/ early referral
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	FWV's provide 24 hour service OB doctor and anesthesia live in quarters, so on-call 24 hours.	If either the OB or anesthesia doctor is sick/ on leave/ doing training- C/S services are not available. Blood has to be purchased from Red Crescent- expensive for poor patients; adds to 3rd delay	Post a junior doctor to learn OB and do first on-call for emergencies. Consider training OB doctors to do spinals
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	MO In-charge and FWV received training and performing neonatal resuscitation Blankets for drying and wrapping newborns Babies stay with mom- breast fed Cord tied with sterile cord clamp	9 bedded ward- slightly crowded- but clean and only post partum moms admitted	Could use better baby resuscitation area in L&D
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	L&D very clean Screen made with sari when needed Essential equipment available- 4 delivery sets kept sterile; have vacuum extractor Most supplies available- Neonatal ambu bag and small mask- no airways seen; have oxygen	Some essential drugs not kept in stock- patient needs to buy from outside: eg oxytocin; magnesium sulphate (only 4 eclampsia pt. Treated in 2004). Sometimes gap between supplies finishing and ordering new: eg foley cath Have to get adult ambu from OT	Improve system for supply management- to minimize drug/ supply shortages
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT clean- Sufficient instruments Sterilization of instruments maintained with autoclave Adult ambu bag, laryngoscope and blades- working; newborn laryngoscope-size 1 blade	Have to get neonatal ambu from L&D; no newborn suction	Need adult and neonatal ambu, masks and airways in both L&D and OT Bulb or foot suction
Overall impressions	Clinic is busy. FWV's do a good job of managing normal cases and initial management of emergencies. Facility is clean and has most basic medicines and supplies	Center is underutilized- but performance could be improved with increase of EmOC staff and beds	Recommend as center of excellence Consider increasing to 20 bed facility with appropriate increase in staff. Consider training SBA's to work in Pouroshova doing safe home deliveries and early referrals to MCWC and DMCH

ANNEX D: Initial Health Facility Assessment Results

Appendix C-6: FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Dinajpur FACILITY: Kanchan NSDP Clinic _

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referral** • **Poor patients**	6 bedded ward Average 32 deliveries; 12 C-sections/ mo Use OGSB protocols Get referrals from CARE; TBA's under the Pourshova; Depo holders; satellite clinics Send a staff with the patients when referred out to District hospital. Fees charged- but less for poor patients and free for least advantaged people	Statistics not readily available- had to estimate from last 3 months Estimated 70-80% patients have episiotomy- should be $\leq$ 10% Emergencies/ complicated cases referred to Dinajpur District Hospital Do not do vacuum deliveries as NSDFP does not allow this.	All delivery staff should have training on use of partogram Decrease routine use of episiotomy Improve reporting on deliveries- use GoB MIS form for EOC MOET/ ?Practical training on vacuum delivery for medical officers
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	2 medical officers- 6 mo trng on OB/Gyn 2 senior nurse midwives- training from OGSB 1 junior nurse midwife 1 OT paramedic	No Surgeon or Anesthetist on staff- called from outside. Not available during office hours.	Minimum MOET training for medical officers
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	No maternal deaths since starting delivery service in March 2001, CEmOC program started in June 2004. Did not have report with SB/ NND -few	Complicated cases referred- so outcomes good for those who deliver at the clinic	
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	24 hour delivery service with midwives MO officer alternate on-duty in daytime and on-call at night; have quarters in building Can do typing and cross matching of blood.	Surgeon and anesthetist both have to be called from outside- increasing chance of delay. Not available during office hours when they are at their own post. Blood has to be brought from outside	Concentrate on providing good delivery services to Basic EmOC level. Consider providing 'walking blood bank' service- since pathology is available.
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	Sr. nurse trained and able to perform neonatal resuscitation; blankets supplied for drying and wrapping newborns Babies breast fed-rooming in- 6 bed ward; Cord tied with packaged cord clamps		KMC training for nursing staff- for management of small/ cold babies
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	Very clean; use chlorine for disinfection 1 labor bed- has curtain on door for privacy 6 delivery sets; necessary drapes/ cloths Have essential medicines in stock: oxytoxic; antihypertensive; anticonvulsant; IV antibiotics; IV's Incinerator for waste disposal	No vacuum extractor Adult and baby ambu bags shared between L&D and OT Emergency drugs not always in stock	Separate resuscitation equipment needed for L&D and OT
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT v. clean; disinfection procedures good C/S set sterilized in autoclave in drums; all necessary equipment available Have C/S box ready- part of pt. bill – with essential supplies and medicines. Newborn and adult ambu bags and laryngo-scope and blades	No puncture proof container for sharps	Puncture proof container for sharps
Overall impressions	Generally clean and well equipped. Rooms well-arranged for patient confidentiality and counseling.	Delivery services opened 3 years back but C-Sections have only been open for 6-8 months. Need time to build up reputation.	Should concentrate on providing OB 1st aid/ Basic EmOC services well before expanding operative services

ANNEX D: Initial Health Facility Assessment Results

Appendix C-7 FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Gaibandha FACILITY: District Hospital

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referral** • **Poor patients**	Currently 50 bed hosp- going to 100 bed Currently 4 female beds- will be 11 Nurses manage eclampsia patients even without consultant Have own ambulance- 18 referred in 2004 Free service- Limited supplies and services	Total deliveries in 2004 = 51 C-sections = 3 (when surgeon was available) Extremely poor utilization- ave. 4/ month- EOC trained midwives should be able to offer OB 1st aid even without medical back-up Partogram not used- no supply No vacuum extractor	Explore reasons for poor utilization of hospital- involve ward health committees/ hospital staff in the process
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	Total of 4 doctors (medical/ENT/ortho/peds) 2 Senior nurse midwives with EOC training	No OB/GYN doctor (since 3 years) No anesthetist Complicated cases referred to Rangpur/ Bogra	Posting of OB/GYN consultant and anesthetist as soon as possible Explore reasons why none of the doctors posted in the last three years have stayed
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	No maternal deaths	Still births= 7 (137/ 1000 total births) ?7 neonatal deaths- forms not filled up properly most of the year (previous Nsg. Sup.)	Need at least 4 midwives with EOC training- to provide OB 1st aid service 24 hours.
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	Midwives on duty 24 hours for deliveries Typing and cross-match can be done	No OB/GYN doctor (since 3 years) No anesthetist Blood brought from Sondhani- takes ½- 1 hour	Arrangements for 24 hour blood availability at the hospital
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	Sr. Nurse Midwife with EOC training is trained and able to do NB resuscitation	Non -EOC trained nurse not confident in NB resuscitation No blankets available for baby drying/wrapping Cord ties not seen	At least 4 midwives need EOC/ ENC training to cover 24 hour service Need separate space for L&D/ post partum
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	Have chlorine in stock to disinfect Steth/ Bp cuff; oxygen and tubes; baby scale; delivery set at nursing station Gloves autoclaved in OT- in drum; some packaged Inj. Antibiotics; sedatives; limited IV supplies on ward	No labor room due to construction- are currently using a side room for deliveries Room was dirty- no water supply- had two recovering eclampsia patients in it. Two regular beds- no partition, no equipment- supplies kept in nursing station Sutures brought from OT if needed	A separate labor room stocked with medicines; supplies; equipment- and water supply is needed- so midwives with EOC training can provide at least OB 1st aid level services
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfection** • **Resuscitation equipment**	One OT currently ready for use- is clean Has anesthesia machine and trolleys; light; operating table that works Autoclave machines working Seem to have main emergency medicines- a new shipment from EOC recently arrived	Most medicines and supplies are dumped on a side table in a store room due to the remodeling Some medicines are expired (Moxin; oxytocin) Resuscitation equipment dumped on table with medicines/ other supplies	OT in-charge needs motivation/ assistance to get equipment and supplies organized/ expired drugs removed

Overall impressions	The new OT /wards will be very nice- but not much use without qualified staff	The hospital currently has only four doctors- but no surgeon or anesthetist. Due to construction everything is in upheaval- and bed space is limited to about 20 altogether. Staff seem disheartened.	There is quite a lot to be done to get this district hospital running as a comprehensive EOC facility

ANNEX D: Initial Health Facility Assessment Results

Appendix C-8 FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Gaibandha FACILITY: MCWC

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referrals** • **Poor patients**	10 inpatient beds; 2 delivery beds Total deliveries 1655 in 2004 C-sections- 149 (Jan-July- 19%) Complicated cases managed: 41 PET; 24 Eclamp; 19 APH; 47 PPH; 156 prlngd lbr; 4 rupt. Uterus; 19 retained placentas Own ambulance- 78 referred in 2004 Free service- most essential items stocked	High patient load for beds/ staff Syntocinon augmentation- 674 (40%)- high Episiotomies- 642 (39%) Aim for ≤ 10% No vacuum extractor MO-clinic left for training in August 2004 and was not replaced until January 2005 Referrals highest Oct-December	Consider expanding to at least 20 beds- with increased staff and equipment as appropriate. Optimally should have one doctor to cover each shift. The doctors not on duty could share on-call for emergencies. Consider teaching all doctors to give spinals
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	MO-Clinic- MBBS, 1 year EOC training MOMCH- MBBS, 1 year anesthesia trng 4 FWV's- all have 6 mo. EOC training 1 FWV comes for ANC days	Staffing is low in relation to patient load	Minimum 6 FWV's for current pt load- should have separate staffing for inpatient/ L&D and outpatient (ANC/FP)
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	No maternal deaths in 2004 55 Stillbirths/ IUFD's- 32.8/1000 total births		
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	FWV's on duty 24 hours OB and anesthesia doctor on-call after office hours 11 units of blood given in 2004 Have generator for electricity supply	Staffing is minimal. If either doctor is gone there are no C-section services FWV's can just cover three shifts- no room for days off/ holidays/ training Blood has to be brought from outside- takes about ½ hour	Consider increasing pathology services to include typing and cross matching and taking blood from relatives. Community education through ward health committees on importance of donating blood.
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	MOMCH, MO, FWV all trained and confident in newborn resuscitation Sterile cord claps available Babies kept with mom- breast fed	No blankets in stock for baby drying/resuscitation- use mom's	Keep stock of flannel blankets for drying/ wrapping newborns Teach MO/FWV's on KMC
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	L&D clean; BP cuff/ stethescope kept in duty room Have scale; suction machine; tube light; minimal delivery instruments; oxygen Essential and emergency medicines available- but not all in one place; also IV's; cannulas; suture; gloves; catheters (reused) Instruments, gowns and gauze autoclaved	No partitions are available for privacy- No spotlight Not enough instruments for number of deliveries (average 4-5/day) Adult ambu kept in OT- if needed for neonate then small mask put on adult bag	Optimum 6 delivery sets for current load
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT clean; chlorine available to disinfect Have oxygen; suction machines (2); anesthesia machine; necessary trollys; light 1 D&C set; 4 C-section sets gloves; sutures; needles; catheters available Emergency medicines and IV's stocked Adult ambu bag and laryngoscope available	Operating table isn't adjustable- also wobbles Some C-section instruments are old and don't work properly- new ones have been requested No suction end for C/S No newborn laryngoscope or ambu bag- small mask is put on adult ambu bag	OT table needs to be fixed or replaced Four full C-section sets should be available
Overall impressions	A busy unit. Staff are hardworking and do a remarkable good job	Inadequate staffing means that quality of care is suffering- partograms not used; BP not done and weeks not assessed in ANC.	Recommend as Center of excellence. Consider increasing beds; increasing staffing and making blood available at the MCWC.

ANNEX D: Initial Health Facility Assessment Results

Appendix C-9 FACILITY ASSESSMENT SUMMARY SHEET

MUNICIPALITY: Joypurhat FACILITY: Modern District Hospital

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal: 1146 Assisted: 91** • **C-Sections: 486** • **Complicated cases** • **Management of labor/recording**	Total del. 2004: 1713 C/S rate 28%- reasonable for referral hospital Manage a variety of complications Use partograph for labor mgmt. Use squatting position in 2nd stage	Still relatively few deliveries in relation to population One ventouse broken; one still in box	Improve community awareness of value of skilled attendance at birth. Improve referral links from TBA's, Union Health Centers, MCWC & SBA's Refresher training on Ventouse delivery for doctors and ?EOC trained midwives
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	2 consultants in ObsGynae One MO 4 EOC trained midwives total	Consultants have to do 1 in 2 on call- if deliveries go up more staff will be necessary. MO has all first call Only 1 EOC trained nurse per shift - need more if deliveries increase.	EOC training for all nurse midwives working in Labor and Delivery
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	SB rate = 76.5/1000 total births- high, but may reflect complicated cases arriving with IUFD from MCWC and other places.	24 Maternal deaths reported in 2004 May reflect large numbers of complicated cases being referred from home/ other facilitiesss	Verbal Autopsies on all Maternal Deaths to determine avoidable factors; points for potential intervention by Poroushova Perinatal Death Audit on SB's and NND's Awareness development of the Community
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	One EOC trained midwife always on duty for Labor and Delivery One consultant always on-call One consultant and two deputies share anesthesia on-call	Consultants do on-call from home- delaying EmOC treatment Have blood bank- but blood not always available. Typing and cross match not always available at night	Consultants do on-call from hospital- or transport arranged for night call Blood bank and typing and cross-matching should be available 24 hours. Community awareness through Poroushova on value of giving blood.
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	Consultants, MO, EOC midwives trained in NB resuscitation- performing confidently. Baby Friendly Hosp.; have fridge for EBM Use thread in spirit for cord tying	Don't have blankets in stock for drying/ wrapping babies Have a radiant heater in peds dept- not working	Staff is motivated- worthwhile giving training in Kangaroo Mother Care for small/ cold babies Consultant Pediatrics should also be involved with Newborn Care
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	Labor and delivery/ pp ward clean and neat; chlorine used for disinfection Screens available for privacy Have new freeze for EMB; wall supply of O2/ suction; basic instruments avail. Have ambu bags /langyngoscope and blades for mom and baby	One ventouse broken Medicine supply irregular Patients have to purchase most medicines/ supplies- delays emergency care Emergency equip. shared between LR and OT- decreasing access	Stock of basic EmOC and emergency medicines and supplies available at all times for poor patients and emergency patients.
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	Both OT's clean Operation tables, instruments, anesthesia and monitoring equipment in good shape Sterilization and decontamination procedures good Have adult and infant laryngoscope	Visitors allowed in OT during surgery in street clothes/ unmasked Use 20g cannula for operation pt.- too small ; have some basic emergency meds- patient has to buy most Sharps put in open bowl Share ambu bags with L&D	Separate adult and newborn/child resuscitation equipment for Labor and Delivery and OT
Overall impressions	Hospital is clean, has basic instruments and is better equipped than many district hospitals. Staff are proud of their facility.	Medicines, supplies and blood are a major problem for poor patients.	Recommend as Center of Excellence for Joypurhat Poroushova.

ANNEX D: Initial Health Facility Assessment Results

Appendix C-10: FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Joypurhat FACILITY: MCWC

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referral** • **Poor patients**	10 bed unit; 1 delivery bed 964 deliveries in 2004 C-Sections 137 (14.2%) Use partogram for monitoring labor Have ambulance: 17 were referred in 2004 Free service- fairly well stocked.	Don't use vacuum extractor Very complicated cases sent to District hospital- including all eclampsia patients Only 37 poor pt according to 2004 report	Improve community awareness of value of skilled attendance at birth. Improve referral links from TBA's, Union Health Centers & SBA's Refresher training on Ventouse delivery for doctors. PNDA training for selected staff Poor patients on top most priority.
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	MO-Clinic, MBBS, MCPS MOMCH, MBBS, 1 yr anesthesia training 4 FWV's- 3 have 6 month EOC training	2 nursing attendant recruited	4 FWV's needed to cover inpatients and L&D and 1 or 2 for outpatients. All FWV's working in L&D should have 6 mo. EOC training.s
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	No maternal deaths SB rate 23.8/1000 total births	Complicated cases are referred to the Sodor hospital artificially lowering mortality stats at the MCWC and raising them at the Sodor	
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	FWV's give 24 hour delivery service to OB 1st Aid level OB and anesthesia doctor on-call after office hours (live in staff quarters) Have generator for electricity back-up	Staffing inadequate to provide 24 EmOC services 365 days/ year- when either doctor is gone patients are referred to Sodor Blood bought from outside- relative/friends donate at private blood bank	Consider adding MO post- give training in spinal anesthesia as well as EOC
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	MO-clinic, FWV's received training in NB resuscitation- confident in performing Have blankets for drying/wrapping NB Babies Friendly- babies with mom/B. fed Sterile cord clamps available		
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	Labor and Delivery clean- chlorine to disinfect; instruments autoclaved 1 bedded delivery room- private Has basic equipment and supplies- oxygen; scale; bulb suction; syringes; gloves; aprons; BP cuff; stethescope Drugs: analgesics; anti-convulsants; sedatives; oxytocics ; IV solutions/ supplies	Only 1 delivery bed- and 2 delivery sets for an average 2.6 deliveries/day Vacuum delivery machine broken Adult ambu bag in OT; no infant ambu bag	Need second labor/delivery bed ; separate adult and neonatal ambu bags for L&D and OT (After the assessment an infant ambu bag was purchased for the OT).
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT fairly clean- instruments autoclaved Have adequate instruments; anesthesia; light; trolleys; BP cuff; stethescope; oxygen; suction; gloves and supplies Emergency drugs and IV's adequate Adult laryngoscope, blades and ET tubes; ambu bag and mask	Resuscitation equipment is in a drawer of the anesthesia trolley and very old and not well maintained- including endotracheal tubes	Could use refresher on resuscitation of newborns. Equipment doesn't seem to be used.
Overall impressions	Busy unit that does a good job of managing mostly normal deliveries. Well equipped and stocked with essential drugs and supplies.	Resucitation equipment doesn't seem to be used- or well maintained	If staff and supplies were increased they could offer 24 EmOC services 365 days/year.

ANNEX D: Initial Health Facility Assessment Results

Appendix C-11: FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Kurigram FACILITY: District Hospital

TOPIC	STRENGTHS	AREA FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referral** • **Poor patients**	Female ward= 13 beds; one labor/delivery bed Treated 363 EOC complications in 2004 Have ambulance Free service- but have to buy most medicines/ supplies	Total deliveries in 2004= 161 C-sections = 13 (January 2005= 15 normal deliveries; 5 c- sections) Vacuum delivery not done Partogram not used; no written protocols 8 patients referred to Rangpur MCH	Poursoshova/ ward health committees to increase community awareness of need for skilled birth attendance. All doctors/nurses working in Labor and Delivery to be trained in use of partogram. Need supply of partograms.
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	1 consultant- MBBS, MCPS, MS surgical consultant/RMO sometime help out 4 EOC trained senior nurse-midwife Total 32 nursing staff- rotate to different wards	Consultant was on study leave for 6 months of 2004 but is now working.	Will need increased staff and separate labor ward/ larger L&D if deliveries increase
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**		7 maternal deaths/ 113 live births = hospital MMR of 6194/1,00,000 live births 52 stillbirths/IUFD= 322/1000 total births	Death audit on all maternal deaths to determine delays as well as medical causes Skilled TBA training to decrease inappropriate interventions and increase early referral for complications
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	Midwives available 24 hours 1 ER doctor available 24 hours for emerg. Consultant on-call- can come in 5-10 min. Anesthesia on-call after office hours (1) Can type and cross match. Blood bank staff on call 24 hours; have generator	Midwives performing forceps deliveries with on the job training- skill level needs to be assessed.	Training nurses to do vacuum delivery would be safer for mother and baby than forceps.
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	OB consultant, Sr. midwife performing resuscitation. Blankets for baby available from OT Some cord ties available for poor pt. Babies stay with mom- breast fed	Families normally give cloth for drying the NB Patients usually buy cord clamp from outside Female ward open- only moderately clean	All midwives doing deliveries need practical training in ENC
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	L&D room clean- attached toilet very clean; chorine used to disinfect No separate labor ward 1 set of delivery instruments kept in L&D autoclaved or boiled between deliveries few dai kits with cotton/gloves; few suture Oxygen bottle- brought from ward Inj antibiotics; oxytoxics available	Baby scale broken- use one from OT Drug / other supply not steady- patients normally purchase needed medicines, gloves, cord clamp, sutures, foley Some IV's kept in nurses' duty room Adult and neonatal ambu bag shared with OT- too far to run in emergency; OT supplies locked at night	All midwives interviewed cited need for supply of essential medicines, more instruments Adult and neonatal resuscitation equipment needed for L&D Keep instruments, meds, essential supplies in delivery room ready for emergency- with door locked, key with nurse in charge
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT generally clean Basic instruments and equipment available: suction; anesthesia. Autoclave working Basic emergency medicines and IV's available in OT store. Oxygen available Adult and neonatal laryngoscope handle and one adult blade; adult ambu bag in OT	Medicines and supplies such as gloves and syringes depend on govt. supplies and so aren't always available No neonatal ambu bag Adult and neonatal laryngoscope blades kept in OT store	A quantity of emergency medicines, anesthetic medicines and supplies need to be kept in OT for emergencies/ poor patients. Resuscitation equipment should be kept together; neonatal ambu bag, masks and airways needed in OT.

Overall impressions	L&D and OT both very clean. Staff trying to do their best with little resources	EmOC services are greatly underutilized, medicines and supplies often not in stock hampering ER treatment and care of poor pt.	

ANNEX D: Initial Health Facility Assessment Results

Appendix C-12 FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Kurigram FACILITY: MCWC

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referral** • **Poor patients**	10 bed ward; 2 bed labor and delivery Total 611 deliveries in 2004 56 C-sections = 9% Episiotomy = 25% 84 D&C's done; 9 PET managed Have own ambulance for referral- 22 patients were referred out in 2004 Free - most meds and supplies available	Deliveries are much higher than the Sodor hospital- but the facility is still underutilized considering the population it serves No vacuum deliveries done- have manual vacuum pump, but the doctor prefers electric. Complications referred to Sodor hospital or Rangpur	Pouroshova ward health committiees to increase community awareness of need for skilled birth attendance. Skilled TBA training to decrease harmful interventions and increase early referral ? SBA's for pouroshova- to increase skilled attendance
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	MO- clinic, MBBS, MPH, DMO, 1 year EOC training MOMCH-FP- MBBS, 1 year anesthesia FWV x 4- 3 have 6 mo. EOC and refreshers	Only 4 FWV's barely covers three shifts- and days off. FWV's staff L&D, post partum , ANC (2 days/week) and FP clinic 2 doctors cannot maintain EmOC services 24hr, 365 days a year	Increase number of FWV's and doctors (EOC trained). Posting of a pediatrician/IMCI trained doctor would improve ability to manage complicated cases
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	No maternal deaths in 2004 24 Stillbirths= 38.6/1000 total births no neonatal deaths	Complicated cases are referred to the Sodor hospital or Rangpur- only 22 cases referred in 2004.	
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	FWV's available for deliveries 24 hours OB doctor and anesthetist can be called from quarters for an emergency 24 hours 9 units of blood given in 2004	Type and cross-match not available- need to get from Sodor Hospital (next door)- increases delay in emergency	Staff and supplies to do typing and crossmatching of blood. Community education on value of blood donation/ need to bring potential donors to hospital with patient (create walking blood bank)
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	MOMCH & FVW with EOC training confident in NB resuscitation Blankets sometimes available for NB Adjustable light for NB warmth during resuscitation. Babies kept with mom- BF		ENC training for all FWV's
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	L&D clean; instruments autoclaved No partitions between delivery beds 3 delivery sets in L&D- 3 more available; two delivery beds; baby light; baby scale Stock injectable antibiotics; oxytocics; anticonvulsants; anti-hypertensives; IV's and supplies Oxygen available	Share suction machine with OT Adult and NB ambu bags kept in OT	Need separate suction machine for L&D and OT Need separate ambu bags, masks and airways for L&D and OT
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT clean; autoclave working; sharps box Instruments and essential equipment avail: foot suction; working table; stethescope; Essential emergency drugs in stock Most supplies in stock: sutures; foley cath; nasal catheters; gloves; IV cannula Adult ambu; adult and infant laryngoscope; oxygen available	No suction machine for mother Neonatal ambu bag with anesthesia doctor Only 1 adult endotracheal tube- no infant tubes	Resuscitation equipment needs to be kept where it can be used by FWV' and doctors
Overall impressions	Generally clean and well stocked. Better utilized than District Sodor Hospital. Has potential to provide service for more women	Need more beds and staff to provide	Recommended Center of Excellence Consider upgrading MCWC to 20 bed; and training SBA's to increase skilled attendance in Pouroshova

ANNEX D: Initial Health Facility Assessment Results

Appendix C-13 FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Nilphamari FACILITY: District Hospital

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referral** • **Poor patients**	Have own ambulance; 57 patients referred in 2004 Free care- Somaj Kallyan provides financial support for medicines and transport and also warm clothes in winter	Total deliveries- 769 Low utilization for district hospital C-Sections- 83 Vacuum delivery not done Partogram not used; BP and FHT recorded in khata	Improve community awareness of value of skilled attendance at birth. Improve referral links with SBAs and TBA's, Union Health Centers and MCWC
Staff: • **Staffing** • **Staff qualifications** • **EmOC/ENC training/skill**	1 OB/GYN consultant- MBBS, DGO 1 anesthetist 4 EOC trained nurses 1 nurse- Repro Health Trng; EOC TOT	Only one female ward. Nurses have to manage L&D; post partum, post op C-Sections and other female patients. Non EOC trained nurses lack confidence/ skill	EOC training for all nurse midwives working in Labor and Delivery- including practical training on use of partogram
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	1 maternal death in 2004	Low maternal mortality could be related to fact that complicated cases are referred before 8 am and after 2 pm Stillbirths/ IUFD-75 = 97.5/1000 total births	Train SBA, skilled TBA's for the municipality, to increase safety of home deliveries and early referral
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	Midwives on duty 24 hours for deliveries OB/GYN doctor and anesthetist available from 8 am to 2 pm	Blood bank only open from 8 am to 2 pm No generator for electricity back-up- often lose power during delivery/ C-Section	Work with Civil Surgeon/ RMO and current EmOC staff to come up with ideas to increase EmOC coverage with current resources Increase medical staff to facilitate 24 hour EmOC-
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	OB doctor, Sr. midwives confident in NB resuscitation Cord tied with sterile thread Babies stay with mother- breast feed	Relatives provide cloth for drying/ wrapping baby No area for performing neonatal resuscitation in L&D; no separate post partum ward	Need partitions to separate post partum mothers/ babies
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	Moderately clean Curtain between beds for privacy Baby scale, delivery beds in L&D Currently have basic emergency drugs- can get some from Social Welfare if no supply is available Have limited IV's /butterfly's/ IV sets (especially during diarrheal episodes)	Equipment is minimal- 2 delivery sets (boiled and put in un-sterile tray) Most equipment, supplies, drugs brought from duty room Syringes/needles thrown in open bin- burned No suction for baby in L&D; no resuscitation equipment for mother or baby in L&D	Organize essential equipment, drugs and supplies in L&D- and lock door- so that everything is ready in one place when patient arrives. At least three delivery sets needed- should be autoclaved
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	Generally clean and well organized 2 sets each for D&C and C/S; autoclaved BP cuff/ stethescope; op table; trolleys; light; oxygen; suction available 2 sets each D&C and C-Section instruments essential emergency drugs available Have adult ambu bag and adult and NB laryngoscope	Broken ampules/ used syringes left lying around OT Baby ambu bag not seen; #1 laryngoscope blade not working	Separate adult and neonatal resuscitation equipment for L&D and OT
Overall impressions	The hospital is overall clean and well maintained. The operation theaters are clean, well-organized and have most essential equipment	Labor and delivery more or less sufficient. Some of the barriers to providing EmOC care could be overcome by increased motivation among key staff.	Has potential for providing increased EmOC services

ANNEX D: Initial Health Facility Assessment Results

Appendix C-14 FACILITY ASSESSMENT SUMMARY SHEET
MUNICIPALITY: Niphamari FACILITY: MCWC

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referral** • **Poor patients**	720 deliveries in 2004 114 C-Sections (15%) 168 episiotomies: 23% Have partograms- staff know how to use New MO-Clinic does Vacuum deliveries; have vacuum extractor Free care- most drugs/ supplies available	Even through 2 FWV's are involved in SBA training they don't often use partograms. Patients come late in labor- staff are busy See small numbers of complications-	Improve community awareness of value of skilled attendance at birth. Improve referral links from TBA's, Union Health Centers and MCWC Skill-base training for TBA's
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	MO-Clinic- MBBS, 1 year EOC training MOMCH- 1 year anesthesia training 5 FWV's- all have 6 month EOC training 2 FWV's are SBA trainers	Only 1 OB/GYN doctor and 1 anesthetist- if one doctor is sick/ on holiday, then C-Sections are not available FWV's cover three shifts plus outpatients	4 FWV's needed to cover 24hour service for inpatients plus 1-2 for outpatients. Use of an SBA to assist with normal deliveries/ ANC could take the pressure off FWV's
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	1 maternal death in 2004 3 still births- 25/ 1000 total births	Complicated cases are referred on to the District hospital- but after 2 pm referrals have to go to Rangpur	
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	FWV's provide 24 hour OB first Aid services OB doctor and anesthetist on- call after office hours Have generator for electricity supply	Blood is brought in from outside lab- causes delay	Upgrade lab to provide typing and cross matching of blood- take blood from patients' donors. Community awareness through Poroushova on value of giving blood.
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	MO-clinic, FWVs performing NB resusc. Blankets for baby drying/wrapping stocked Have incubator for warmth during resusc. Sterile cord ties supplied Babies stay with mother- breast feed		Give FWV's with SBA TOT training in Kangaroo Mother Care
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	L&D and ward are clean 3 delivery sets; BP cuff and steth; incubator for NB resuscitation; light; scale Essential drugs and IV's; supplies available FWV in charge of supplies keeps stock of medicines and supplies for emergencies/ poor patients Neonatal ambu bag and mask available	2 beds in labor and delivery- screen is not used as it makes it hard to work Oxygen is kept in OT- brought when needed Adult ambu bag in OT;	Provision for privacy in L&D that doesn't obstruct movement when not in use. Adult and neonatal ambu bags in both L&D and OT
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	OT clean Equipment in good condition: suction; Op. table; trolleys; oxygen available All essential drugs and supplies available Adult and NB laryngoscope and blades; adult ambu back and mask	Only 2 C-Section sets- reasonable for current load- but another set would be useful if deliveries increase When stocks are low patients who can afford it are asked to buy meds/ supplies Share NB ambu with L&D	
Overall impressions	Facility is clean and generally well-equipped and well stocked. Episiotomy and C/S rate is reasonable in comparison with other MCWC's	Quality of care could be improved by use of partogram	? recommend as center of excellence?

ANNEX D: Initial Health Facility Assessment Results

Appendix C-15 FACILITY ASSESSMENT SUMMARY SHEET

MUNICIPALITY: Rangpur FACILITY: MCWC

TOPIC	STRENGTHS	AREA FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referral** • **Poor patients**	Beds= 10 L&D beds = 2 Total deliveries= 1001 D&C= 55 248 cases had synto augmentation- 24.8%- need chart audit to determine if appropriate Have own ambulance for referral Service free-most meds/supplies are stocked	C-sections- 200 = 20% A bit high for this type of facility- but 51 cases of obstructed labor were recorded. Eclampsia is referred Vacuum deliveries not done Partogram is not used always- have supply No written protocols- verbal	Increase to 20 bedded unit with appropriate increase in staffing. Refresher training in partograph/ MOET for select staff Practical training in vacuum delivery for OB doctor
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	MO- Clinic MBBS, DGO MOMCH- MBBS, MPH, 1 year anesthesia 5 FWV's- 4 with 6 mo EOC training	5 FWV's cover three shifts (average 3 deliveries/day) as well as outpatient ANC/PNC/FP. Adequate coverage is difficult, if anyone is sick/on leave/ training	At least one more doctor with EOC skills needed . More EOC trained FWV's to enable separate staffing of L&D/ pp ward Posting of a pediatrician/ IMCI doctor would increase ability to manage emergency cases
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	No maternal deaths in 2004 4 stillbirths = SB rate of 4/1000 live births	Complicated cases are referred to RCMH	PNDA training for selected staff
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	FWV's on duty 24 hours MO-Clinic on-call Anesthetist on-call.	Only 1 OB doctor and one anesthetist- if either is gone there is no C-section service Blood is drawn to send to RMCH -only 3 units given in 2004	Increased staff- as above
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	MO-clinic, FWV's all trained and confident in NB resuscitation; have blankets for drying and wrapping newborn Cord ties disinfected with hexaol Babies stay with moms- breast fed	Have heat lamp for L&D- sent for repair	Consider Kangaroo Mother Care training for select staff- for better care of small/ cold infants
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	L&D clean. Use chlorine for disinfection Have vacuum extractor; suction machine Delivery instruments autoclaved Heat lamp for newborns Most essential meds in stock: oxytoxics; sedatives; inj. Antibiotics; IV solution Essential supplies in stock; O2 available	No screen between labor/delivery beds Only 2 delivery sets- inadequate for pt. load Generally don't manage eclampsia- so MgSO4 not in stock No sharps box	Optimum- 6 delivery sets for anticipated increased load Method for providing privacy Separate adult and neonatal ambu for L&D
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	Basic equipment available- BP cuff/stethoscope; anesthesia/ trolleys/trays/ light/ suction ER drugs and supplies available Instruments duly autoclaved/ disinfected Ambu and neonatal ambu with masks Neonatal laryngoscope and blades- works	Only 1 D&C set- 2 C-section sets- inadequate for client load	At least one more each D&C and C-section set.
Overall impressions	The MCWC is clean, busy and staff are hard working.		Recommend as Center of Excellence for Rangpur. Increase in beds and staffing would enable provision of a broader range of EmOC services. Appointment of EMO.

ANNEX D: Initial Health Facility Assessment Results

Appendix C-16 FACILITY ASSESSMENT SUMMARY SHEET

MUNICIPALITY: Rangpur FACILITY: Bangabandhu Memorial Hospital

TOPIC	STRENGTHS	AREAS FOR IMPROVEMENT	RECOMMENDED ACTION
Current delivery case load/ mgmt: • **Normal; Assisted; C-Sections** • **Complicated cases** • **Management of labor/recording** • **Referral** • **Poor patients**	Total 25 beds- 3 cabins (all patient) 1 delivery/ operation bed Have own ambulance (pouroshova)	Currently 8-10 deliveries/ month- 3-5 C-Sections/ month; 1-2 D&C's / month; vacuum delivery not done Little capacity to manage complications Partogram not used- no protocols for L&D Complicated cases referred to RCMH- takes ½- 1 hour	Consider training a group (3-4) of skilled birth attendants to do normal deliveries at the hospital. Train one nurse in advanced midwifery to serve as supervisor (at least 6 wk EOC refresher course) Enlist support of Pouroshova to increase community awareness on need for skilled attendance at birth
Staff: • **Staffing** • **Staff qualifications** • **EmOC training/skill**	5 doctors total 3 Senior Nurse-Midwives	No doctor with EOC training None of the midwives have EOC training- all are inexperienced	MO given MOET training All midwives be given EOC refresher course
Outcomes: • **Maternal outcomes** • **Perinatal outcomes**	Maternal and perinatal outcomes good	Very few deliveries done so far- complicated cases referred	
24 hour EmOC service • **Midwives/FWV** • **OB/Gynae doctor** • **Anesthesia** • **Blood**	Midwives available for normal deliveries 24 hours Have generator for continuous electric supply	MO available on-call, but no EOC training OB consultant and anesthetist called in from outside- takes 40-45 minutes to come- Blood – has to be bought from private supplier- 7 km distance	Concentrate on developing a good OB 1st Aid facility and then gradual upgrade services to Basic EmOC- perhaps Comprehensive EmOC sometime in future
Newborn care: • **Resuscitation** • **Warming/ feeding** • **Infection prevention**	Female MO and Sr. Nurse confident in neonatal resuscitation Have towels for drying/wrapping newborn Post partum area clean- wards small, not crowded; babies stay with mom- breast feed	Patient buys cord clamps from outside Nursing staff is all relatively new- pt volume is still low- so aren't getting much experience	All midwives be trained in ENC and to acquire knowledge for position and attachment for breast feeding.
Labour and Delivery • **Cleanliness** • **Privacy** • **Equipment** • **Emergency drugs/supplies** • **Resuscitation equipment**	L&D/ OT very clean Only one bed- OK for privacy Instruments and equipment new: delivery set; suction machine; light; Some supplies available: gloves, IV cannula Basic IV's; sedatives available Have Oxygen	L&D and OT in same room- will make separate L&D when deliveries increase Most medicines and supplies purchased by patient from drug stores: anticonvulsants; oxytoxics; Inj. antibiotics Oxygen supply not always available	Need to purchase neonatal ambu bag Batteries should be stored with laryngoscope
Operating Theatre • **Cleanliness** • **Equipment** • **Emergency drugs/supplies** • **Sterilization- disinfect ion** • **Resuscitation equipment**	C/S set x 7; D&C set x 1 Instruments autoclaved Newborn and adult laryngoscope and blades; adult ambu bag and mask	Plan to buy diathermy for OT Sharps not put in separate container adult laryngoscope had no batteries; no newborn ambu bag/ mask/ airways	As above. Will need separate resuscitation equipment for L&D and OT when they become separate.
Overall impressions	The facility is newly remodeled and clean. There is a lot of new equipment There is commitment to provide good services and a community support group	Staff working in labor and delivery have no training and little idea of EmOC.	There is a need to provide good safe delivery services on this side of the city- consider starting with SBA's working under an EOC trained midwife

Reducing smoke, improving child health

Indoor air pollution kills huge numbers of children in Bangladesh. How is Concern tackling it?

Because cooking is done so close to the family's main living area, a large percentage of under-fives have serious respiratory symptoms.

The issue of Indoor Air Pollution has been officially incorporated into the activities of Concern Worldwide's Health Programme since it was included in the organisational Health Policy of March 2002. The health programme is broadly divided into three inter-related and inter-dependent components, namely nutrition, reproductive and child health and environmental health.

Environmental Health, in addition to indoor air pollution, incorporates the technical components of water, excreta disposal, liquid and solid waste management (including drainage), hygiene promotion, shelter and site planning and vector control. These components have been chosen in order to make a significant contribution to reducing the current disease burden in targeted countries.

Since the appointment of Concern's first Environmental Health Adviser in 1999, field workers have been able to call on technical support on each of the aspects outlined above. Indoor Air Pollution is now being tackled in a small but growing number of the 30 countries Concern currently operates in. Bangladesh (whose activities are described more fully below) and Liberia have actively engaged in this area since 2004, with Haiti currently looking at the issue and Tanzania recently including a research element for inclusion in a new five-year water and environmental-health programme.

Ensuring child survival in Bangladesh

Concern Bangladesh began implementing a Child Survival Programme in October 2000. Initially focusing on the municipalities of Saidpur and Parbatipur of Rajshahi Division in northern Bangladesh, the programme focused on the key health interventions of immunisation, Vitamin A, IMCI (Integrated Management of Childhood Illness) — including acute respiratory infections (ARIs), diarrhoea, malnutrition and maternal and newborn care with a view to reducing maternal and child mortality among urban residents. The programme is conducted in partnership with the respective municipalities.

Following an environmental-health technical-support visit in October 2003 the programme began to look at indoor air pollution as a potential intervention area. This was prompted by the findings of a WELL (Water and Environmental Health at London and Loughborough) study in 2002 that stated that diarrhoeal disease associated with inadequate water supply, sanitation and hygiene practices — and ARIs associated with overcrowding and indoor air pollution, represent 30 per cent of all deaths in Bangladesh.

Doing the research

A recently completed baseline study explored the magnitude of the impact of indoor air pollution on the health of children in a poor, urban community in Bangladesh.

Researchers carried out a cross-sectional baseline survey with 625 households, measuring the indoor-air-quality in 65 households, all of which had children younger than five. They also collected anthropometric information on 444 children under 5 — and 282 children were medically examined for possible respiratory problems.

All the households in the project area use biomass-burning stoves. The fuel is predominantly wood (47 per cent) but also includes rice-husk briquettes (18 per cent), dung cakes (13 per cent), bamboo (11 per cent) and others (11 per cent). Data showed that 32 per cent of households cooked in the living room, 13 per cent used a veranda (close to the door of the living room) while 55 per cent had outdoor kitchens.

Because the cooking area is so close to the living area, however, even in the non-cooking period the particulate matter (PM 2.5) concentration indoors is at least twice the USEPA 24-hour average limit (65 micrograms per metre^3). The prevalence of coughs (43 per cent) and other respiratory symptoms are very common among children under five. Lack of awareness, inefficient design of stoves and poor ventilation contribute to the high levels of indoor air pollutants.

This research has convinced Concern Bangladesh that they can do useful work on reducing exposure to indoor air pollution, which will contribute to improving child health. It will also provide valuable learning to guide future interventions for other developing countries. Concern Bangladesh acknowledges the financial support of the United States Agency for International Development (USAID) and technical support from Winrock International and Dr. Mohammad Alauddin.

***Niall Roche** is Concern's Environmental-Health Adviser. **Subir Kumar Saha** is Concern's Research Co-ordinator. For more on the work of Concern, go to www.concern.net*

Work Plan of Municipal Health Partnership Program, DIP Year-3

(Oct, 2006 – Sep, 2007)

No.		Q1	Q2	Q3	Q4	Concern	Partner	
Objective 1: Sustained municipal health systems for maternal and child health in 7 municipalities								
Ward Level								
01	Monthly meetings of WHC (80% Meeting Conduction Targeted)	X	X	X	X			75X12= 900 meetings
02	WHC Annual plan development	X	X					75
03	WHC capacity assessment	X	X	X				75
04	WHC support mechanism development for Least Advantaged Groups		X					59 Ward
05	Health Day Observation (World Health Day, World Breast Feeding week, Safe Motherhood Day, World AIDS Day)	X		X	X			5X7X5=175
06	Training on Participatory Planning for WHC selected members	X						75X3=150
07	Orientation Package for WHC Members	X						8X20=160 participants
08	WHC Refresher Training			X	X			
09	WHC Capacity tool Development	X						
10	Cross visit for WHC Members			X	X			75 Batch
Municipality Level								
11	MESPCC Quarterly Progress Sharing Meeting	X	X	X	X			28 Meeting (80% Attendance Attendant of that Meeting)
12	Municipal Annual Health Plan Development	X	X					90%
13	Training on Health staff for HMIS data entry			X				14 MHS (7x2)
14	Implement HMIS at 7 municipalities level	X	X	X	X			7 Munis
15	Facilitation Skill building for MHD on conducting WHC self- assessment	X	X					75 people
16	HICAP Review for 7 municipalities		X	X				7 Munis
17	KPC Survey using LQAS methodology for mid term in 7 municipalities and LC for post interventions evaluation.		X	X				2 times X7 Munis = 14
18	Conduction of Mid Term evaluation				X			7 Munis
19	Research findings sharing with stakeholders				X			1 Events
20	WHC Annual Progress Shearing meeting at Municipality Level		X					1 Event/ Municipality
21	Leadership Dev. Training for WHCs selected members			X	X			75X3=225participants
22	Problem Solving & Decision Making Training for Cabinet Members			X				7 Batch
23	Training on supportive supervision technique for MHS & Supervisor			X				2 Batch
24	Coordination meeting with other NGOs		X		X			7X2=14 Meeting (Semi. Annual)
25	Municipality Inter Dept. Coordination Meeting		X		X			7X2=14 Meeting (Semi. Annual)
26	Partnership review with Municipalities and NSDP		X		X			2 times
Learning Center								
27	Efforts for increasing health sector budget allocation	X						1 + 1
28	Progress sharing meeting with CHV, TBA, Imam & Teacher	X	X					Att-70%
29	WHC Progress sharing meeting	X	X					4
30	WHC Annual plan development	X						
31	TOT refresher for MHS- LC	X						
32	Lesson learned sharing with stakeholders		X					2
33	Exit Plan Development and sharing	X						1 (This Quarter)
34	MESPCC progress sharing meeting	X	X					2 X 2 =4
35	Host exposure visit	X						
36	Continuous implementation of HMIS	X	X					2 LCs
37	Documentation of LC experiences	X	X					
38	Follow up of on-going health activities at Municipality & WHC (capacity assessment) and prepared periodical report	X	X					8 sessions X 2 LCs= 16
39	Sharing the lesson learned with Project team		X					4 sessions in 4 Qus

Objective 2: Improved household prevention and care practices for sick children								
Ward Level								
1	Selection and training of community health volunteers-CHV(50 House hold per Volunteer)	X	X					1654 persons
2	CHV bi-monthly meeting	X	X	X	X			450 meeting
3	CHV Annual progress sharing meeting (70% meeting conduction targeted)		X	X				14 Session(2x7 Municipa)
4	CHV Refresher Training		X	X	X			1721 CHV
5	Training of School teachers		X	X	X			40x7=280 Teachers
6	Follow up Meeting With teachers Semi Annually				X			2x7=14 Meetings
7	Selection of PP Facilitator (MBBS)	X						20 MBBS Doctor
8	Training of PPs (RMP-3 Ward)		X	X	X			225 (3x75)
9	Training of PPs (Homeopaths-40 in Kurigram and Nilphamari)				X			40
10					X			2 Mtng
11	Followup Meeting with PPs (RMP)		X	X	X			7 Mtng
12	Training of Religious leaders (6+/- Imam per Ward)		X	X				286
13	Followup Meeting with religious leaders (Imam)		X	X				7 mtng
14	Refersher training for Religious Leader (Imam)				X			164 Imams
15	Selection and training of Religious leaders -Purohit (25)				X			25 dinajpur
Municipality Level (new 7)								
16	IMBCT Semi Annual Meeting	X		X				2x7 = 14 meeting
Research								
17	Established effective service delivery system for Iron and Zinc Supplementation for Children (With UNICEF & ICDDR,B collaboration)				X			1 event
Learning Center								
18	Facilitate BCC activities as per BCC strategy	X	X					
19	CHV training on Basic health messages	X	X					120 CHVs
19	Establishing referral tracking of PP with Health facility	X	X					
20	PP training	X	X					
National (IMCI Linkage)								
21	Participation at IMCI NWT meetings	X	X	X	X			as need
22	Dissemination of Lessons learned				X			
22	Participation in National training pool for C-IMCI	X	X	X	X			
23	IMCI trainign-Counselling Package (5 days) for MHS			X	X			
23	Training for PP facilitator (11 days)	X	X					20
Regional level								
24	Approval from Education deparment (from GOB for school involvement)	X						

25	Developing teachers training module(2 modules for Primary and Secondary school)	X						2
25	Developing Purohit training module		X	X				1
26	Developing Homeopathy training module	X	X	X				1
26	CHV,Imam training module endorsement	X	X					2
27	Learning Visit- Nepal	X						1 team
27	Learning Visit- ICDDR.B-Matlab	X						
28	Develping referral systme between PP and Health facility			X	X			
28	Develping Job Aid/BCC materials (for stakeholders, CHVs, MHS)	X	X					
29	TOT for PP Facilitator	X	X					20 PP Moderators
29	PP monitoring system develop	X	X					1

Objective 3: Improved Maternal and Newborn Care Practices						
Activities	**Qtr-1**	**Qtr-2**	**Qtr-3**	**Qtr-4**		
Endorsement of CBA (formerly TBAs) curriculum	X					
Finalise MOU/ letter of support on 'Centre of Excellence'	X					
Training of CBAs based on revised CBA training guideline		X	X		75X3= 225 CBAs	Each batch contain 8-10 members
Refresher training of Trained CBAs by CBA Trainer				X	112 CBAs	50% of total CBAs
Establish system of tracking CBA referral to health facility			X			Same as PP referral
Quarterly meeting of CBA at Health Facility			X	X	7X2=14	Two in each Pourashava
Workshop on continuous Quality Improvement at the health facilities		X	X		7X1= 7 MO of MCWC	
Support to 'Centre of Excellence' for quality improvement		X				
Quality Assurance Orientation and self assessment for MESPCC members		X			7X1= 7 MO of MCWC	From each Pourashava
Municipality diagnosis (service, QoC, Referral & community function)			X	X	7X1=7	
Technical update to MESPCC member on clean and safe delivery		X	X			
Learning visit to LAMB's safe delivery centre by Municipal stakeholders		X	X		7X1=7	12-15 person from each Pourashava
MOET (Management of Obstetric Emergencies & Trauma) training for Doctors of Govt. Maternal & Child Welfare Center		X	X		One batch contains 8 participants	MOs of MCWC & NSDP
PNDA (Prenatal Death Audit) training (2nd batch) for MOs of MCWC		X	X		One batch contains 8 participants	MOs of MCWC & NSDP
Doer/Non-doer analysis on Iron folate supplementation, food intake during pregnancy, delivery at health facilities	X	X				3-4 behaviour After IMBCT workshop
Study on WHC social & financial support mechanism and its impact on maternal & newborn emergencies				X	25 WHCs	One third of total WHC
Participation in National & Regional Maternal & Child Health forum	X	X	X	X	2 per year	

Learning visit to Maternal & Newborn Health project	X	X			8-12 person from MHPP & stake	Home & abroad

Child Survival and Health Grants Program Project Summary

Oct-30-2006

Concern Worldwide Incorporated (Bangladesh)

General Project Information:

Cooperative Agreement Number:	**FAO-A-00-00-00039**
Project Grant Cycle:	**20**
Project Dates:	**(9/30/2004 - 9/29/2009)**
Project Type:	**Cost XT**
CWI Headquarters Technical Backstop:	**Michelle Kouletio**
Field Program Manager:	**Dr. Syed Izaz Rasul**
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Funding Information:

USAID Funding:(US $): $1,500,000 **PVO match:(US $)** $693,657

Project Information:

Description:

This cost extension project is to scale up the successful municipal health program developed by CWI. The project goal is to reduce maternal and child mortality in nine municipalities in Rajshahi Division.
The priority interventions are: maternal and newborn care, pneumonia case management, nutrition, and diarrheal disease.

The strategies include; fostering learning and networking across and within municipalities; strengthening partnership and technical capacity among the Municipality Health Departments and private, government and NGO service providers; building more effective management capacity of the Municipal Authorities; and community led health promotion emphasizing male involvement, participation, and social support for income poor households.

Location:

Rajshahi Division

Project Partners	Partner Type	Subgrant Amount
MOLGRD	Collaborating Partner	
MOHFW	Collaborating Partner	
LAMB	Subgrantee	$22,643.00
UNICEF	Collaborating Partner	
ICDDRB	Subgrantee	$30,000.00
NSDP	Collaborating Partner	
Subgrant Total		$52,643.00

Project Sub Areas:
Bogra
Dinajpur
Gaibandha
Joypurhat
Kurigram
Nilphameri
Rangpur

General Strategies Planned:

Private Sector Involvement
Advocacy on Health Policy
Strengthen Decentralized Health System

M&E Assessment Strategies:

KPC Survey
Health Facility Assessment
Organizational Capacity Assessment with Local Partners
Participatory Rapid Appraisal
Participatory Learning in Action
Lot Quality Assurance Sampling
Appreciative Inquiry-based Strategy
Community-based Monitoring Techniques
Participatory Evaluation Techniques (for mid-term or final evaluation)

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication
Peer Communication
Support Groups

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
(None Selected)	PVOs (Int'l./US) Local NGO	Pharmacists Traditional Healers Private Providers	Dist. Health System Health Facility Staff Other National Ministry	Health CBOs Other CBOs CHWs

Interventions/Program Components:

Nutrition (20 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Comp. Feed. from 6 mos.
- Maternal Nutrition

(IMCI Integration)
(CHW Training)
(HF Training)

Pneumonia Case Management (25 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Pneum. Case Mngmnt.
- Case Mngmnt. Counseling
- Recognition of Pneumonia Danger Signs
- Community based treatment with antibiotics

Control of Diarrheal Diseases (15 %)

(IMCI Integration)
(CHW Training)
(HF Training)
- Hand Washing
- ORS/Home Fluids
- Feeding/Breastfeeding
- Care Seeking
- Case Mngmnt./Counseling

Maternal & Newborn Care (40 %)

(IMCI Integration)
(CHW Training)
- Emerg. Obstet. Care
- Neonatal Tetanus
- Recog. of Danger signs
- Newborn Care
- Post partum Care
- Delay 1st preg Child Spacing
- Integr. with Iron & Folate
- Normal Delivery Care
- Birth Plans
- Home Based LSS

(IMCI Integration)

Target Beneficiaries:

	Bogra	Dinajpur	Gaibandha	Joypurhat	Kurigram	Nilphameri	Rangpur	Total Beneficiaries
Infants < 12 months:	3,978	3,835	1,589	1,002	1,370	922	6,179	18,875
Children 12-23 months:	3,978	3,835	1,589	1,002	1,370	922	6,179	18,875
Children 0-23 months:	7,957	7,670	3,179	2,004	2,739	1,844	12,358	37,751
Children 24-59 months:	11,935	11,505	4,768	3,006	4,109	2,766	18,538	56,627
Children 0-59 months:	19,892	19,175	7,947	5,010	6,848	4,610	30,896	94,378
Women 15-49 years:	47,447	45,738	18,957	11,951	16,335	10,997	73,697	225,122
Population of Target Area:	182,490	175,917	72,910	45,966	62,826	42,297	283,448	865,854

Rapid Catch Indicators:

LQAS sampling methodology was used for this survey

UNDERWEIGHT CHILDREN

Description -- Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)

Numerator: No. of children age 0-23 months whose weight (Rapid CATCH Question 7) is -2 SD from the median weight of the WHO/NCHS reference population for their age

Denominator: Number of children age 0-23 months in the survey who were weighed (response=1 for Rapid CATCH Question 6)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	67	222	30.2%	9.4
Dinajpur	78	214	36.4%	10.3
Gaibandha	70	177	39.5%	11.7
Joypurhat	61	174	35.1%	11.3
Kurigram	65	177	36.7%	11.4
Nilphameri	72	179	40.2%	11.7
Rangpur	117	280	41.8%	9.5

BIRTH SPACING

Description -- Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child

Numerator: No. of children age 0-23 months whose date of birth is at least 24 months after the previous sibling's date of birth (Rapid CATCH Question

Denominator: Number of children age 0-23 months in the survey who have an older sibling

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	201	260	77.3%	11.8
Dinajpur	196	276	71.0%	11.3
Gaibandha	141	215	65.6%	12.6
Joypurhat	163	200	81.5%	13.6
Kurigram	165	215	76.7%	13.0
Nilphameri	156	225	69.3%	12.4
Rangpur	278	358	77.7%	10.1

DELIVERY ASSISTANCE

Description -- Percentage of children age 0-23 months whose births were attended by skilled health personnel

Numerator: No. of children age 0-23 months with responses =A ('doctor'), B ('nurse/midwife'), or C ('auxiliary midwife') for Rapid CATCH Question 10D

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	149	240	62.1%	11.7
Dinajpur	114	300	38.0%	8.9
Gaibandha	100	179	55.9%	13.1
Joypurhat	81	180	45.0%	12.2

Kurigram	61	181	33.7%	10.9
Nilphameri	95	180	52.8%	12.9
Rangpur	114	300	38.0%	8.9

MATERNAL TT
Description -- Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child

Numerator: Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9

Denominator: Number of mothers of children age 0-23 months in the survey Number of mothers of children age 0-23 months with responses=2 ('twice') or 3 ('more than two times') for Rapid CATCH Question 9 Denominator Numerator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	166	240	69.2%	12.0
Dinajpur	110	239	46.0%	10.7
Gaibandha	64	179	35.8%	11.2
Joypurhat	71	180	39.4%	11.6
Kurigram	72	181	39.8%	11.6
Nilphameri	53	180	29.4%	10.4
Rangpur	113	300	37.7%	8.8

EXCLUSIVE BREASTFEEDING
Description -- Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours

Numerator: Number of infants age 0-5 months with only response=A ('breastmilk') for Rapid CATCH Question 13

Denominator: Number of infants age 0-5 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	64	121	52.9%	15.7
Dinajpur	80	118	67.8%	17.1
Gaibandha	66	106	62.3%	17.6
Joypurhat	81	110	73.6%	18.0
Kurigram	62	93	66.7%	19.2
Nilphameri	61	95	64.2%	18.8
Rangpur	103	154	66.9%	14.9

COMPLEMENTARY FEEDING
Description -- Percentage of infants age 6-9 months receiving breastmilk and complementary foods

Numerator: Number of infants age 6-9 months with responses= A ('breastmilk') and D ('mashed, pureed, solid, or semi-solid foods') for Rapid CATCH Question 13

Denominator: Number of infants age 6--9 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	97	119	81.5%	17.7
Dinajpur	100	121	82.6%	17.5
Gaibandha	68	73	93.2%	22.9
Joypurhat	54	70	77.1%	22.8
Kurigram	86	88	97.7%	20.9
Nilphameri	75	85	88.2%	21.1
Rangpur	130	146	89.0%	16.1

FULL VACCINATION
Description -- Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday

Numerator: Number of children age 12-23 months who received Polio3 (OPV3), DPT3, and measles vaccines before the first birthday, according to the child's vaccination card (as documented in Rapid CATCH Question 15)

Denominator: Number of children age 12-23 months in the survey who have a vaccination card that was seen by the interviewer (response=1 'yes, seen by interviewer' for Rapid CATCH Question 14)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	204	240	85.0%	12.5
Dinajpur	194	236	82.2%	12.6
Gaibandha	129	179	72.1%	14.1
Joypurhat	156	180	86.7%	14.5
Kurigram	146	179	81.6%	14.4
Nilphameri	152	181	84.0%	14.4
Rangpur	255	300	85.0%	11.2

MEASLES

Description -- Percentage of children age 12-23 months who received a measles vaccine

Numerator: Number of children age 12-23 months with response=1 ('yes') for Rapid CATCH Question 16

Denominator: Number of children age 12-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	206	240	85.8%	12.5
Dinajpur	199	236	84.3%	12.6
Gaibandha	135	179	75.4%	14.2
Joypurhat	157	180	87.2%	14.5
Kurigram	153	180	85.0%	14.4
Nilphameri	158	181	87.3%	14.5
Rangpur	262	300	87.3%	11.2

BEDNETS

Description -- Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)

Numerator: Number of children age 0-23 months with 'child' (response=A) mentioned among responses to Rapid CATCH Question 18 AND response=1 ('yes') for Rapid CATCH Question 19

Denominator: Number of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	0	0	0.0%	0.0
Dinajpur	0	0	0.0%	0.0
Gaibandha	0	0	0.0%	0.0
Joypurhat	0	0	0.0%	0.0
Kurigram	0	0	0.0%	0.0
Nilphameri	0	0	0.0%	0.0
Rangpur	0	0	0.0%	0.0

DANGER SIGNS

Description -- Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment

Numerator: Number of mothers of children age 0-23 months who report at least two of the signs listed in B through H of Rapid CATCH Question 20

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	223	240	92.9%	12.6
Dinajpur	221	236	93.6%	12.7

Joypurhat	151	180	83.9%	14.4
Kurigram	173	180	96.1%	14.6
Nilphameri	169	181	93.4%	14.5
Rangpur	292	300	97.3%	11.3

SICK CHILD

Description -- Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks

Numerator: Number of children age 0-23 months with response=3 ('more than usual') for Rapid CATCH Question 22 AND response=2 ('same amount') or 3 ('more than usual') for Rapid CATCH Question 23

Denominator: Number of children surveyed who were reportedly sick in the past two weeks (children with any responses A-H for Rapid CATCH Question 21)

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	15	39	38.5%	24.7
Dinajpur	23	49	46.9%	23.7
Gaibandha	14	36	38.9%	25.9
Joypurhat	18	54	33.3%	19.9
Kurigram	13	65	20.0%	14.6
Nilphameri	17	70	24.3%	15.3
Rangpur	25	63	39.7%	19.7

HIV/AIDS

Description -- Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection

Numerator: Number of mothers of children age 0-23 months who mention at least two of the responses that relate to safer sex or practices involving blood (letters B through I & O) for Rapid CATCH Question 25

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	159	240	66.3%	11.9
Dinajpur	138	236	58.5%	11.6
Gaibandha	83	179	46.4%	12.4
Joypurhat	97	180	53.9%	13.0
Kurigram	88	180	48.9%	12.6
Nilphameri	92	181	50.8%	12.7
Rangpur	206	300	68.7%	10.7

HANDWASHING

Description -- Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated

Numerator: Number of mothers of children age 0-23 months who mention responses B through E for Rapid CATCH Question 26

Denominator: Number of mothers of children age 0-23 months in the survey

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra	64	240	26.7%	8.6
Dinajpur	48	236	20.3%	7.7
Gaibandha	32	179	17.9%	8.4
Joypurhat	45	180	25.0%	9.7
Kurigram	22	180	12.2%	7.0
Nilphameri	20	181	11.0%	6.7
Rangpur	12	300	4.0%	3.2

TB TREATMENT SUCCESS RATE

Description -- Percentage of new smear positive cases who were successfully treated

Numerator: Number of new smear positive cases who were cured plus the number of new smear positive cases who completed treatment

Denominator: Total number of new smear positive cases registered

Sub Area Name	Numerator	Denominator	Percent(calculate)	Confidence Limits
Bogra			%	
Dinajpur			%	
Gaibandha			%	
Joypurhat			%	
Kurigram			%	
Nilphameri			%	
Rangpur			%	

Comments for Rapid Catch Indicators