



**USAID – MUNICIPALITY-  
CONCERN WORLDWIDE BANGLADESH  
MUNICIPAL HEALTH PARTNERSHIP PROGRAM**

**MID-TERM EVALUATION REPORT**

**Bogra, Dinajpur, Gaibandha, Joypurhat, Kurigram, Nilphameri,  
Rangpur Municipalities, Rajshahi Division, Bangladesh**

**Cooperative Agreement No. FAO-A-00-98-00077-00**

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## ACRONYMS

ANC	Antenatal Care
AIDS	Acquired Immuno-deficiency Syndrome
ALRI	Acute Lower Respiratory Infection
BCC	Behavior Change Communication
BMMS	Bangladesh Maternal Mortality Study
CBA	Community Birth Attendant
CHV	Community Health Volunteer
CSP	Child Survival Program
CSTS	Child Survival Technical Support
CSSA	Child Survival Sustainability assessment
CORE	Collaboration and Resource Group
HMIS	Community health management information system
C-IMCI	Community Based IMCI
DIP	Detailed Implementation Plan
EmOC	Emergency Obstetric Care
ESPCC	Essential Services Package Coordinating Committee
FP	Family Planning
FT	Field Trainer
GoB	Government of Bangladesh
HICAP	Health Institution Capacity Assessment Process
HNPSP	GoB Health, Nutrition and Population Strategic Plan 2003-2006
IAP	Indoor Air Pollution
ICDDR,B	International Center for Diarrheal Disease Research, Bangladesh
IMBCT	Inter-Municipality Behavior Change Team
IMCC	Inter-Ministerial Coordinating Committee
IMCI	Integrated Management of Childhood Illnesses
JHU	Johns Hopkins University
JSI	Johns Snow Inc.
KPC	Knowledge, Practice and Coverage Survey
LAG	Least Advantaged Group
LAMB	Lutheran Aid to Medicine in Bangladesh
LC	Learning Center
LQAS	Lot Quality Assurance Sampling
MCWC	Maternal and Child Welfare Center
MEOC	Management of Emergency Obstetric Care
MHPP	Municipal Health Partnership Program
MHS/D	Municipality Health Staff/Department
MMO	Municipal Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOLGRD	Ministry of Local Government and Rural Development
MTE	Mid-term Evaluation
NGO	Non-Government Organization
NSDP	NGO Service Delivery Program (USAID)
NID	National Immunization Days
OJT	On the Job Training
PM	Program Manager
PP	Private Practitioners (formal and informal)
POP	Phase Out Plan
QoC	Quality of Care
TT	Tetanus Toxoid
UNICEF	United Nations International Children's Fund
UPHC	ADB Urban Primary Health Care Program
USAID	United States Agency for International Development
WHC	Ward Health Committee
WHO	World Health Organization

## I. INTRODUCTION

The goal of USAID's Child Survival and Health Grants Program (CSHGP) is to contribute to sustained improvements in child survival and health outcomes by supporting the work of US-based PVOs and their local partners. An essential aspect of these grants is an evidence-based Mid-Term Evaluation (MTE) which not only assists in monitoring and documenting the project's achievements but also examines the potential sustainability of the project's health achievements.

Concern Worldwide engaged a review team to conduct the MTE of the five-year (October 2004—September 2009) Municipal Health Partnership Program (MHPP) in Rajshahi Division, Bangladesh. The review was carried out between 18 August and 6 September 2007.

### A. Terms of Reference

Working in close partnership with nine municipalities, Bogra, Dinajpur, Gaibandha, Joypurhat, Kurigram, Nilphamari and Rangpur, as well as Saidpur & Parbatipur (the original Child Survival Project or CSP municipalities), the goal of the MHPP is to reduce maternal and child morbidity and mortality. According to the Terms of Reference (**Attachment I**), the MTR was to be a participatory exercise to assess the process, performance and technical effectiveness of the program as well as develop overarching lessons learned and provide recommended actions to guide the project staff through the last half of the project. Although the evaluation team consisted of a number of persons involved in the MHPP, it was led by two impartial and objective consultants who have considerable experience in Child Survival and health programming in Bangladesh and elsewhere.

The three objectives of MHPP to be evaluated were:

- Sustained improvements in the quality of municipal maternal and child health systems.
- Improved preventive and care-seeking practices for sick children.
- Improved maternal and newborn care practices.

Concern Worldwide Bangladesh does not directly deliver these services. Rather, as a program facilitator, they devote their time to building the capacities of the municipal health managers and health department as well as raising awareness and mobilizing available resources at the community or ward<sup>1</sup> level.

### B. Evaluation Team

Concern Worldwide US and Bangladesh formed a core MTR team that included thirteen persons from various partners in the MHPP, who participated on a full-time or part-time

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<sup>1</sup> Wards are the smallest administrative urban units, ranging in population from several thousand in the smaller municipalities to over 10,000 in the larger municipalities.

basis, led by two external consultants (**Attachment II**). The team was constructed with gender balance in mind and included a Clinic Manager from the NGO Service Delivery Program (NSDP), a MHPP technical resources partner. Several members from the respective Municipalities were included in the MTE team: one Female Ward Health Commissioner from Joypurhat; one WHC leader from Kurigram; and one WHC member from the Gaibandha Municipal Health Department (MHD). In addition, national stake holders were included: the Program Manager, MCH, Office of Directorate General for Family Planning and the Deputy Program Manager, Neonatal Health, IMCI Section, Office of Directorate General for Health Service, both from the Ministry of Health and Family Welfare (MOHFW). The Deputy Chief (Planning) of the Ministry of Local Government and Rural Development was also an MTE team member.

There were five Concern Worldwide Bangladesh staff members on the team:<sup>2</sup> the Senior Health and Nutrition Advisor, the MHPP Program Manager, the Regional Manager, the Technical Manager for Research and the Learning and Documentation Manager.

Dr. David F. Pyle, Senior Associate of John Snow, Incorporated (JSI) based in Washington, DC, was the Team Leader of the MTE team. Dr. Fatema Zannat, Quality Improvement Coordinator for University Research Corporation (URC), served as Deputy Evaluation Team Leader, focusing attention on Quality of Care (QoC) aspects of the program. In addition, the Program Officer, Health from Concern Worldwide US, Allyson Brown, MPH, was a member of the core MTE team.

## **C. Methodology**

The MTE of the MHPP involved a number of different components. First, the Team Leader interviewed senior staff at USAID/CSHGP prior to traveling to Bangladesh to review the MTE terms of reference and seek CSHGP's feedback regarding potential MTE report outcomes (e.g. discussion of MHPP lessons learned). Second, the MTE Team reviewed a large volume of documents and secondary data, including program documents, survey reports and training curricula (**Attachment III - List of References**). As part of the program's monitoring and evaluation plan, the MHPP carried out a number of studies and surveys, including population Knowledge, Practice and Coverage (KPC) surveys in 2004 and 2007, a Health Institution Capacity Assessment Process (HICAP) survey in 2005 and a Health Facility Assessment in 2005. In addition, WHC Capacity Assessments were conducted in the seven MHPP municipalities in 2007. Prior to the MTE site visits in the Rajshahi Division, the core MTE team also met with key stakeholders at USAID Bangladesh in Dhaka to seek their input and Pathways Consulting Services, the external consultants who conducted the KPC, to discuss the KPC findings.

The MTE team organized pre-MTE meetings at the national and municipal level to gain stakeholder feedback and input on methodologies (**Attachment IV - Agenda and List of**

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<sup>2</sup> In addition to the five Concern Worldwide Bangladesh staff members who worked on the core MTE team, several MHPP staff members provided administrative and logistical support as well as participated in the national and municipal level stakeholder consultations.

Participants). At the municipal-level stakeholders meeting, it was agreed that a random selection of four of the seven MHPP municipalities would be selected for the MTE site visits through a 'lottery' (i.e., the names of the municipalities were put in a hat and drawn); Bogra, Dinajpur, Gaibandha and Kurigram were selected. With a focus on sustainability, the MTE team arranged site visits to the Learning Center municipalities established in Saidpur and Parbatipur as well.

The MTE Team was divided into two teams, one led by Dr. Pyle (Bogra, Gaibandha and Saidpur site visits) and one led by Dr. Zannat (Dinajpur, Kurigram and Parbatipur site visits).<sup>3</sup> Key informant interviews and focus group interviews (**Attachment V** - List of Persons Interviewed) were the primary source of data collection to substantiate project results, identify lessons learned and make recommendations for the remainder of the project period. The MTE team reviewed and analyzed the findings and agreed on the MTE findings, lessons learned and recommendations.

Post-evaluation meetings were held with USAID and municipal and national stakeholders (**Attachment VI** - Agenda and List of Participants), where the MTE findings and recommendations were shared and discussed in presence of the MOLGRD & C Additional Secretary and an official from MOHFW.

## **D. Report**

The Mid-Term Evaluation Report of the MHPP consists of several chapters. The following chapter provides background information on Concern Worldwide Bangladesh, a summary of the MHPP's objectives and approach and a brief overview of the urban health situation in Bangladesh. Chapter Three is the major section of the report, focusing on results and findings. It is divided into several sections relating to capacity building in the health services, at the municipal level and at the community/ward level. There is also a section that explores cross-cutting issues such as training, behaviour change, quality of care, sustainability and operations research. The MTE team examined factors for success, best practices and describes tools/methodologies that have been employed. Recommendations are interspersed throughout the chapter and follow from the discussion of the findings.

The next chapter reviews various aspects relating to Concern Worldwide's management of the program, concentrating on the field but also relating to the Dhaka and New York offices as appropriate. The final chapter contains major conclusions of the MTE and lessons learned that can be applied elsewhere. This chapter also includes a consolidation of recommendations into a limited number of priority suggested actions that Concern Worldwide US and Bangladesh should consider as it proceeds with the final two years of the project and focuses on sustainability of the MHPP urban health capacity-building

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<sup>3</sup> Due to insecurity on August 23<sup>rd</sup>, the Team leaders were not able to travel to Dinajpur and Bogra; however the core MTE members based in those municipalities proceeded with the planned key informant and focus group interviews. The Team leaders, who were based in Rangpur, interviewed key stakeholders in Rangpur, including clients at the Maternal and Child Welfare Center, CBAs and a WHC.

approach in northern Bangladesh, as well as potential replication to other municipalities throughout the country.

## **II. BACKGROUND**

### **A. Concern Worldwide Bangladesh**

Concern Worldwide Bangladesh began operations in Bangladesh in 1972 by providing post-war relief to refugees. Over the last three decades, the organization has focused on working for the advancement of the poor and most vulnerable people of the country. Reaching over one million direct beneficiaries in 2006, Concern Worldwide Bangladesh works in five sectors: Livelihoods Security, Education, HIV & AIDS, Emergency Response and Disaster Management and Health and Nutrition.

Until the mid-1990s in the health sector, Concern Worldwide delivered a package of health, nutrition and family planning services. After an evaluation in 1995-6, which found Concern's health program in Bangladesh to be one of the most expensive health efforts worldwide in terms of cost per beneficiary, Concern Worldwide Bangladesh adopted a new strategy to improve cost-effectiveness and sustainability. It shifted from direct health care delivery in the slums to attempting to harness the potential of municipal authorities and existing resources in the community through capacity building and the development of partnerships.

Concern Worldwide Bangladesh's current strategic objective for health and nutrition is "to adopt innovative approaches which contribute toward developing and strengthening the health system in both urban and rural Bangladesh and to ensure quality health and nutrition services can be accessed by the extreme poor." An essential aspect of achieving Concern's strategic objective for health and nutrition is the Municipal Health Partnership Program (MHPP), which employs an innovative approach to facilitating health system strengthening and aims to improve the health status of mothers and children in selected urban municipalities in northern Bangladesh.

### **B. Municipal Health Partnership Program**

The MHPP, a USAID/CSHGP cost extension, aims to scale-up the successful predecessor grant (CSP) by Concern Worldwide in Bangladesh. The predecessor program in Saidpur and Parbatipur municipalities in Rajshahi Division established a promising model for providing health care services with demonstrated increases in coverage, practices and effective civil society and local government engagement in health.

Launched in October 2004, the MHPP is greatly expanding (more than six fold) and adapting this model to seven additional municipalities in Rajshahi Division: Bogra, Dinajpur, Gaibandha, Joypurhat, Kurigram, Nilphamari and Rangpur. Learning Centers

have been established in Saidpur and Parbatipur to facilitate scaling-up efforts and provide a locus for national policymakers, municipality authorities and community members to observe and learn how to replicate and sustain the experience.

By scaling-up the municipal health model, the MHPP hopes to demonstrate its applicability in municipalities that are larger and more diverse than the original two and sustainability within the existing resources of municipalities, the Government of Bangladesh and civil society.

The Program goal is to reduce maternal and child mortality in seven municipalities in Rajshahi Division, Bangladesh, reaching 225,122 women of reproductive age and 94,377 children under-five over the next five years.<sup>4</sup>

**Table 1**  
**Population in the Program Location, 2005**

Municipality	Wards	Population Estimated 2005	Women of Reproductive Age (15-49)	Children 0-59 months
Nilphamari	9	42,297	10,997	4,610
Kurigram	9	62,826	16,335	6,848
Gaibandha	9	72,910	18,957	7,947
Dinajpur	12	175,917	45,738	19,175
Rangpur	15	283,448	73,697	30,896
Bogra	12	182,490	47,447	19,891
Joypurhat	9	45,966	11,951	5,010
<b>Sub total</b>	<b>75</b>	<b>865,854</b>	<b>225,122</b>	<b>94,377</b>

Note: WRA and under 5 children are calculated considering 26% WRA and 11% children of total urban population. Annual urban growth rate 3.1%. Data Source: BBS, Planning Division, Ministry of Planning, GoB, July 2003

The Program objectives are: (1) Sustained improvement in quality of maternal and child health systems; (2) Improved household prevention and care-seeking practices for sick children; and (3) Improved maternal and newborn care practices.

Priority interventions are targeted at the major causes of maternal and child mortality in municipal areas, namely:

- Maternal and newborn care (40% level of effort [LOE]),
- Pneumonia case management (25% LOE),
- Nutrition and micronutrients (20% LOE) and
- Diarrhoeal disease control (15% LOE).

Interventions are in line with national priorities from Bangladesh Health, Nutrition, and Population Sector Program (HNPS 2003-2006); the Essential Services Package (ESP); the National Maternal Health Strategy 2001-2010; and the Facility and Community-IMCI Strategies. Most importantly, MHPP is turning the municipal health structure,

<sup>4</sup> An additional 49,500 WRA and U5s are indirect beneficiaries of sustained and reinforced child survival interventions in Saidpur and Parbatipur. The MHPP includes activities that will directly affect the population, but due to the changed role as a Learning Center, they are not counted as direct beneficiaries.

which was established in the mid-1990s, from something that exists only on paper to something that functions and improves the health status of the population.

The following four major strategies are being employed:

- (1) Fostering learning and networking across and within municipalities;
- (2) Strengthening partnership and technical capacity among the municipality health departments and private, government and NGO service providers;
- (3) Building more effective management capacity of the municipal authorities;
- (4) Advancing community led health promotion emphasizing male involvement, participation and social support for income poor households.

The primary implementation partners are the nine Municipal Authorities under the Ministry of Local Government, Rural Development and Cooperatives (MOLGRD&C) and seven District Civil Surgeon's offices and seven Deputy Director Family Planning offices under the MOHFW. In addition, the MHPP is collaborating with UNICEF, the Lutheran Aid to Medicine in Bangladesh (LAMB) Project, International Center for Diarrhoeal Disease and Research in Bangladesh (ICDDR,B), and the USAID-supported NGO Service Delivery Program (NSDP) in their capacities as technical resource organizations. In turn, all of these organizations are represented on the Project Advisory Committee (PAC), which provides overall technical guidance to the Program, advocates for the support of its objectives, and disseminates learning to outside audiences.

### **C. Urban Health Situation in Bangladesh**

In Bangladesh, under-five mortality rate is 88 per 1,000 live births (BDHS, 2004) with leading causes of death of pneumonia, diarrhea, malnutrition, accidents and neonatal complications. The newborn mortality rate is 41 per 1,000 or approximately two-thirds of the infant mortality rate.

Overall more than a quarter of the Bangladesh population resides in urban/municipal areas. This translates to almost 36 million people, and the number is increasing rapidly. Half of Bangladesh's urban population resides in municipalities, or secondary cities or towns, with an annual population growth rate of 3.1% (BBS, 2003) and where 25% of the children live in households in absolute poverty of less than \$1 per day (UNICEF 2003). Urbanization is increasing at an estimated 4.6% per annum. Consequently, urban centers are expected to increase to 33% of the population (or over 50 million) by 2010. The absolute poor are most vulnerable to disease and limited access to quality health care and mortality.

Urban health services are the responsibility of the MOLGRD&C. According to the Municipal Administration Ordinance 1960, the *Pourshava* Ordinance of 1977 and the City Ordinance of 1983, Municipalities and City Corporations (CCs) are charged with providing preventive health and limited curative care. However, urban health policy gaps between the Municipalities, MOHFW and MOLGRD&C and lack of adequate financial resources devoted to health have resulted in understaffing, absence of community health promotion, and limited coordination among the private (for profit), government and NGO

service providers. Consequently, these limitations have prevented public health services from keeping up with municipal health needs.

As Concern Worldwide Bangladesh was developing the original Child Survival Project in Saidpur and Parbatipur, the project was influenced by a circular from MOLGRD&C in 1995 which clearly stated about the PHC service delivery at urban level through effective participation of municipality and community along with health service provider by forming three level committees- 1) Inter-Ministerial Coordinating Committee (IMCC), 2) Municipal Essential Services Package Coordinating Committee (MESPCC), and 3) Ward Health Committee (WHC). Concern Worldwide Bangladesh identified these two entities as the core of the CSP and developed a project that built the capacity of these two bodies to improve and sustain quality maternal and child health services. As mentioned above, the MHPP is now building on the previous success of this predecessor program in Saidpur and Parbatipur and is scaling-up the model in partnership with seven additional municipalities in Rajshahi Division.

In the Rajshahi Division, health services are delivered by a variety of public and not-for-profit private sector, facility-based providers. They include both outpatient and inpatient child health care through district and medical college hospitals; and ante-natal and post natal care, emergency obstetric care (EmOC) and family planning services through district and medical college hospitals and Maternal and Child Welfare Centers (MCWC) of the Family Planning Directorate of MOHFW.

In the for-profit private sector, there are a plethora of individual and group providers practicing health care, from MBBS (Bachelors of Medicine and Bachelors of Surgery) qualified physicians to multiple informal “private practitioners” (PPs) such as homeopaths, Rural Medical Practitioners (RMPs) and “quacks” or barefoot/untrained doctors. Formal and informal health services of the municipality are mostly concentrated in the centers of the municipalities, resulting in access problems for peri-urban residents.

Taken as a group, NGO providers deliver a medium to high quality of facility-based services in the seven municipalities. In the seven MHPP municipalities, there are 16 fixed or “static” clinics and hospitals, ten of which are NSDP-affiliated (3 each in Dinajpur and Rangpur and 1 each in Nilphamari, Bogra, Kurigram and Joypurhat) and four Family Planning Association of Bangladesh (FPAB) clinics plus two Mary Stopes Clinics (in Rangpur and Bogra). The NGOs that are associated with the USAID/Bangladesh-funded NSDP, a resource partner in the MHPP, are in 6 of the 7 municipalities (excluding only Gaibandha). The MHPP is engaging these NGOs in order to increase access of mothers and their children to the targeted interventions, and build their own capacity in community mobilization and Behavior Change Communications (BCC), ultimately, in order to take over the role of the MHPP at the end of the grant period.

### III. RESULTS AND FINDINGS

The project results achieved in the first half of the MHPP have been impressive. Emphasis in the initial phase of the project has been the establishment of the structure and laying the foundation for the community-based health program in a considerably larger population than served in the preceding Child Survival Project (CSP) upon which model the MHPP is based. Although the process aspect has consumed a significant proportion of Concern's effort during this period, considerable progress has also been made in increasing community awareness and changing behaviors in important health practices such as vitamin A supplementation, antenatal care, delivery at a health facility and breastfeeding. Concern Worldwide has carried out a number of data-gathering exercises which provide information on the capacities in health service delivery as well as at the municipal and ward management levels.

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

#### A. Capacity Building – Technical Services

To achieve MHPP objectives of improved maternal and newborn care as well as child health (ARI and diarrhea), infant feeding (nutrition and micronutrients) and care seeking behaviors, Concern Worldwide identified a need to strengthen the capacity of serviced-providing facilities and workers. Through a series of training, MHPP upgraded the skills of the municipal health workers in management of EPI, provision of vitamin A supplementation, basic health messages and behavior change communications (see **Attachment VII** – review of MHPP trainings). These interventions were supported by extensive supervision and monitoring.

1) **Results:** Despite the six-fold increase in population coverage and the heavy commitment to process and building the community and municipal health structure, Concern Worldwide invested considerable energies in improving the services and knowledge/practices relating to the primary interventions identified in the MHPP Detailed Implementation Plan (DIP) – i.e., maternal and child health and Community-Integrated Management of Childhood Illnesses (C-IMCI). The findings of the Knowledge, Practice and Coverage (KPC) survey conducted prior to the launch of the

MHPP interventions were compared to the results of the KPC completed in early 2007 (**Attachment VIII** – KPC 2007 Report) demonstrated that the MHPP made good progress at this mid-way point toward achieving its objectives and targets stated in the project proposal. While Concern lists 53 “major indicators”, the mid-term review team decided to focus on some of the most important outcome indicators. Table 2 provides data on 13 of the most important indicators.

**Table 2**  
**MHPP Intervention Outcomes - Baseline vs. Mid-Term KPC**  
**(In Seven MHPP Municipalities)**

<b>Indicator</b>	<b>Baseline (2005)</b>	<b>Mid-Term KPC</b>	<b>EoP Target</b>
<b>I. Maternal and Newborn Care</b>			
ANC – 3 or more visits	58%	66%	-
Iron supplementation (90 days)	42%	54%	60%
More food than usual	32%	38%	45%
Birth preparation	16%	14%	30%
Delivery in health facility	44%	49%	-
Delivery with skilled attendant	49%	54%	60%
Delivery with skilled or trained attendant	59%	66%	80%
Vitamin A postpartum	25%	39%	50%
<b>II. Child Health (ARI and Diarrhea)</b>			
ARI – seek treatment	45%	74%	60%
ARI prevalence	17%	11%	NA
Diarrhea – seek treatment	42%	57%	-
Diarrhea prevalence	13%	8%	NA
More food/liquids during diarrhea	38%	31%	50%
Immunization (12-23 months)	82%	90%	-
Mothers washing hands at 5 critical times	16%	20%	30%
<b>III. Nutrition and Micronutrients</b>			
Breastfeeding initiation (within 1 <sup>st</sup> hour)	40%	44%	60%
Complementary food (6-11 months)	27%	28%	45%
Vitamin A (12-23 months)	59%	73%	85%
Underweight (-2SD)	38%	36%	-

A few indicators were not selected because of concern that they did not accurately reflect the situation. See sub-section b below on Child Health for several examples.

Of the indicators included in Table 2, each one deserves a comment. They will be discussed in accordance to the priority interventions as identified by Concern Worldwide

in their proposal – starting with maternal and newborn care, followed by child health, including pneumonia case management and diarrheal disease control, and, finally, nutrition and micronutrients.

Before reviewing the data it should be mentioned that a stakeholder suggested that a control group be added during the final evaluation to help draw a causal link between MHPP and any health improvements that are found. This is a reasonable idea although it would depend on locating a municipality that is matched or very similar to the seven MHPP municipalities. Using the LQAS methodology, it would add only marginally to the final evaluation costs.

**Recommendation #1:** Concern Worldwide should consider adding a control municipality to the final evaluation so that achievements of the MHPP can be more attributable to the project interventions.

**a. Maternal and Newborn Care (40% of Level of Effort or LOE)**

Significant progress was achieved by the MHPP during its first two and a half years. The MTR team was constantly and consistently impressed by the Community Health Volunteers (CHVs) and Community Birth Assistants (CBAs) that it had the<sup>5</sup> opportunity to meet with and interview. They are, almost without exception, committed and highly active.

**Box #1 – CBA Motivation (Rangpur)**

*If I help to save these babies, I am helping to save the future of the nation.*

The indicator of three or more **Antenatal Care** visits indicate progress (a more than 13% increase) has been made in this intervention. This ranged from a low of 53% in Giabandha and a high of 80% in Dinajpur. Those women receiving at least one ANC visit went from 65% to 93%. This compares favorably with the 2004 Bangladesh Demographic and Health Survey (BDHS) which found 75 of the women in urban centers had one or more ANC visits and 59% in Rajshahi Division (urban and rural combined), in which the seven MHPP municipalities are located.

It was learned that 35% of the mothers made their **first ANC visit** to a service provider or health facility before completing four months of their recent pregnancy. This was up slightly from the baseline which was 31%. When analyzing the ANC data by income group, it is not surprisingly that the number of ANC visits by the poor is inversely related. In the MHPP municipalities, 75% of the richest asset quintile make 5 or more ANC visits while only 12% of the poorest quintile make that number.

**Box #2 – CBAs Assist Doctor/Head MCWC (Rangpur)**

<sup>5</sup> Concern Worldwide used to refer to the CBAs as Tradition Birth Attendants (TBAs). The name was changed because the Ministry of Health (MOH) issued a directive saying that TBAs were no longer to be recognized or supported. The MOH subsequently agreed to refer to them as CBAs.

*CBA's are helpful for us. Yesterday, a CBA brought four patients...Generally they bring the poor people.*

The MTR team identified a constraint that limits ANC coverage and could discourage women from seeking adequate care during pregnancy. All the Maternal Child Welfare Centers (MCWCs), operated by the Ministry of Health and Family Welfare (MOHFW), conduct ANC sessions two days a week. They explain this practice as being caused by a lack of sufficient medical support at the facilities. These centers typically have one obstetrician and one anesthetist and 4-5 Family Welfare Visitors (FWVs). However, the MCWCs that were visited had a number of FWVs who had mid-wife training and could competently provide antenatal care. In fact, the heads of the MCWCs said that the FWVs carried out ANC services on all six days a week that the centers were open, but that the obstetrician only saw patients on the two days assigned for ANC.

The MCWC in one of the municipalities visited by the review team, a **limit** of 40 women are seen. Reportedly, it is common that over 100 pregnant women show up on the appointed days and the majority go home without having been seen. It is expected that such frustration will result in a decrease in the percentage of pregnant mothers presenting themselves for ANC or reduce the number of times they go. Thus, the MHPP efforts to increase demand should be matched with efforts to increase the supply of ANC services.

**Recommendation #2:** The ANC patient load for the **MCWCs** in the seven municipalities should be studied and measures taken to assure that ANC services are available (using paramedical staff as required) to satisfy the demand.

The KPC collected data on the types of ANC services that the women received. Increases were seen in things like being weight, blood pressure taken, and fetal position monitored, blood tested and urine checked. The percentage of women being given **iron folate tablets** almost doubled to just over half. In addition, there was an increase of almost 28% in the number of women taken 90 days or more of the iron supplements. With such a high percentage of mothers in Bangladesh suffering from iron deficiency anemia, this is a positive development. Education and income levels are positively correlated with higher iron intake. Despite the increases, the MHPP End of Project (EoP) target is 60% so there is more progress to be made.

Another important indicator of program effectiveness in the maternal health component involves **food intake** during pregnancy. A common practice is for mothers to consume less food to limit the size of the newborn to facilitate delivery. The majority of Bangladeshi women are under-nourished to begin with so decreasing food consumption can have a detrimental impact. One all too common result of this tradition exacerbates the serious problem of a high incidence of low birth weight infants. To address this problem, the CHVs and CBAs raise the awareness of the mothers to the need to increase their nutrient intake when they are pregnant. The almost 19% increase in the percentage of pregnant mothers increasing their food intake indicates that the MHPP message was being delivered and understood by the target population. Performance by municipality

ranged from a high of 61% of the mothers consuming more food in Joypurhat to a low of 21% in Bogra and Nilphamari. With the EoP target being 45%, the project must continue to emphasize the importance of increasing food intake prior during pregnancy.

Encouraging pregnant women and their families to give serious thought to various aspects of delivery was an integral part of the MHPP approach. For example, **birth preparation** includes consideration of where the delivery would take place, transport that might be required (if not at home) and resources that would be needed. It is interesting that this indicator did not show any improvement. During the last two years of the project, MHPP will have to give special attention to this particular aspect if their end of project target is to be reached.

A great deal of success was achieved in the CSP in births **delivered at health facilities**. By the end of the project, approximately two-thirds of the deliveries were carried out in a health establishment. The percentage went up in the MHPP municipalities by a little over 11% and it currently stands at just under half. Institutional deliveries were highest in Bogra (65%) and lowest in Kurigram (26%). The higher the age, education level and asset quintile, the better the chance that the mother will deliver in a health facility. The 2004 BDHS reports that only 9% of the deliveries in Bangladesh took place in health facilities (both public and private). This increases to 22% in the urban centers but is only 8% in the Rajshahi Division, making the MHPP considerably better in this regard.

The two delivery-related indicators tracked by the MHPP are delivery by skilled attendants and **skilled attendants or trained CBA**. Both of these indicators showed improvement and progress toward the end of project targets is being achieved.

**Box #3 – CHV Motivates Mother for Facility Delivery (Kurigram, Ward 5)**

*Recently a CHV identified complications in a pregnant woman in her zone. She counseled the mother and was able to convince her that she needed to go to the MCWC. The CHV requested the WHC to provide [money for] transportation which they did. The child was delivered successful and both mother and child are doing well.*

There was also a slight increase in the percentage of births conducted by **skilled and trained providers** (e.g., doctor, nurse, FHV, CBA). Cost was found to be the primary cause for delivering at home.

The use of **mother health cards**, as recommended in the CSP final evaluation, was not found to be practical as they are not in use by the government elsewhere in the country. The **birth preparedness cards** were in evidence when the review team visited the field and were being used effectively as a guide for ensuring that pregnant women and their families make the necessary preparation for the forthcoming delivery.

In general, there was an 11% increase in the percentage of mothers who were examined by a health provider within 48 hours of delivery. The indicator chosen to represent postnatal care is the delivery of **postpartum vitamin A** with 42 days of the birth. Here

the increase was slightly more than 11%, but it failed to reach more than three out of every five mothers in the MHPP municipalities. The project has a target of reaching 50% of the mothers. As in the case of the under-five vitamin A supplementation, one of the reasons given for not reaching the target is lack of supplies.

Two indicators normally included, such a **contraceptive prevalence** and tetanus toxoid coverage are not covered here for several reasons. The review team did not select it as an indicator for two reasons. One, it is not an explicate objective of the MHPP although the CBAs, and to a lesser extent the CHVs, motivate women that have had a child recently or has too many already to adopt contraception. Thus, its influence is only tangential. Second, the CPR (modern methods) was already high to start with (68%). It was not significantly higher in the mid-term KPC (69%). It was highest in Bogra (72%) and lowest in Gaibandha (52%). The most surprising finding is that the use of injectables decreased significantly (from 13% to 4%). In the past, it was highly popular. One explanation given was lack of supplies.

The **birth intervals** in the MHPP municipalities increased during the first several years of the project. Whereas the baseline found that there were three or less years between births in 26% of the cases, there were 20% in the mid-term KPC, a reduction of 23%. This has a far-reaching impact on the health of both mother and child. The gap between the last two births in the seven project cities was 66 months which compares favorably with national figures which in 2004 was 43 months in urban areas of Bangladesh (BDHS).

**Tetanus Toxoid** coverage was high in the baseline (85%) and was increased to 90% in the follow-up survey (at least one TT immunization in last pregnancy). This high level of coverage made it less likely that significant increases would be achieved.

#### **b. Child Health – ARI and Diarrhea (25% and 15% of LOE, respectively)**

Concern Worldwide is very actively involved in IMCI and C-IMCI effort in Bangladesh. They have advocated and championed the cause of C-IMCI since the latter stages of the CSP. The MHPP has been active in all components of C-IMCI – ARI, diarrhea, immunization and nutrition. The first three will be discussed in this sub-section and the last one will be covered in the following sub-section.

♦ *ARI/Pneumonia* – The prevention and treatment of ARI is included in the training of all the field personnel of the project – especially the CHVs and other members of the Ward Health Committee (WHC). The community volunteers raise the awareness of the caretakers, informing them of the danger signs and the need to get treatment early when their child has symptoms of coughing, fever and/or fast/difficult breathing or chest in-drawing.

While **Private Practitioners (PPs)/Rural Medical Practitioners (RMPs)** sit on most of the WHCs, the project has not begun the training of the PPs/RMPs as was scheduled in the DIP. Concern Worldwide was entrusted with the responsibility of development of a

training/negotiation guide for RMPs by the IMCI national working team which will be used for the nationwide expansion of C-IMCI in Bangladesh. Concern Worldwide has developed a training module for negotiation session used to involve PPs/RMPs in the MHPP. This is based on findings from research that Concern Worldwide carried out on PPs/RMPs in the CSP. The module has been submitted to the national IMCI working team for review and endorsement. Technical experts in the various components of IMCI made comments and modifications on the module. The module has been field tested in Dinajpur and the module along a facilitator's guide and job aids and referral form is currently being printed. Training of the PPs/RMPs is expected to commence soon. This is important since studies show that over 40% of the mothers take their children to PPs/RMPs when they become ill.

In addition to the PPs/RMPs, **homeopaths**, another common source of child treatment especially in northern Bangladesh, will receive training (as recommended in the CSP final evaluation). MHPP has collaborated with a Medical Officer-Homeopathy from Nilphamari to produce a training module for homeopathic practitioners to increase their knowledge and skills in managing sick children and counsel mothers.

**Recommendation #3:** PP/RMP and homeopath training should begin as soon as possible and be expedited so that these practitioners can become active supporters of improved child health practices.

Despite the lack of trained PPs/RMPs, the message seems to be getting across to the target population. The percentage of children showing symptoms of ARI within the previous two weeks who sought treatment increased almost 65%. In the follow-up KPC nearly three out of four were treated. Considering the high rate of **treatment** of children with ARI symptoms, the percentage of mothers of children 12-23 months who know fast/difficult breathing and chest in-drawing as specific **danger signs** of pneumonia was lower than expected. The KPC found that 38% of the mothers knew the signs (versus 26% in the baseline and a target of 45%).

The MTR team was also weary of a few of knowledge indicators. For instance, the danger signs and **hand washing** questions are likely to be directly correlated with the amount of time that has passed since the training took place (i.e., scores will be lower if training was given several years ago and higher if recently carried out). As an example, performance in hand washing was poor, primarily because the indicator required that the respondent give all five specific activities before and after which hands are to be washed with soap and water. Giving four of the five was counted as an incorrect response. This makes it difficult to determine whether progress is being achieved.

It is not clear why or if the MHPP can take any credit for it, but the **prevalence** of ARI among the under-five population in the two weeks prior to the KPC was significantly reduced – from a baseline of 17% to 10%, a more than 40% reduction. It is possible that health education provided by MHPP and the CHVs and improved practices could have made a difference. It would be interesting if the project could look into this and determine a cause for lower ARI prevalence.

◆ *Diarrhea* – Bangladesh has a long history of using Oral Rehydration Solution (ORS). It pioneered the intervention decades ago. Oral Rehydration Therapy (ORT) has become a household practice throughout much of the country. The review team observed that the **indicator** of the percentage of mothers of children 0-23 months who provided ORS for diarrhea caused considerable confusion. Some mothers in Bangladesh have moved beyond the use of ORS packets and use either home-made *laban-gur* (salt-sugar) mix or a cereal-based (e.g., rice water) formula. In the mid-term KPC, for example, 65% of the mothers used the ORS packet to rehydrate their sick child, while another 10% gave home-made solutions and 6% cereal-based therapy. The figure for ORS does not accurately reflect that over four out of every five mothers give their child suffering from diarrhea one form of ORT, all of which have been proven effective. If the question used the term “ORT” instead of “ORS”, the percentage would be more accurate. Even one of the mothers interviewed by the MTR team pointed out that the ORS indicator is not appropriate. A commissioner of Kurigram who was involved with KPC team also had strong comments about the questioning during survey on diarrhea treatment. (Data Collector asked ORS instead of ORT)

**Recommendation #4:** Adopt an indicator for diarrhea treatment that refers to ORT and includes all three forms of rehydration.

MHPP achieved significant success in getting the message across to the mothers concerning the **danger signs** and symptoms of diarrhea. The percentage knowing them went from 31% to 61%, almost doubling and surpassing the End of Project (EoP) target of 50%.

There was also an increase in the percentage of children suffering from diarrhea who were **treated**. It improved by more than 35%, from 42% in the baseline to 57% in the most recent KPC, surpassing the EoP target of 50%.

One of the few MHPP indicators that did not show progress was **increased food/liquid consumption** during diarrhea. In fact, there was a decrease in this activity. MHPP should conduct some focus group discussions to determine barriers to this behavior and strengthen their communications messages on this subject to improve performance during the last half of the project.

As is the case with ARI **prevalence**, the percentage of children with diarrhea during the previous two weeks from 13% in the baseline to less than 8% (a 38% reduction) in the mid-term KPC. Again, the cause and how it can be attributed to MHPP interventions is not clear.

The close relationship between the CBAs and the MCWC is obviously very important to the effective collaboration between them. Since the CBAs spend 18 days at the MCWC during their training, they know the MCWC providers and the latter get to know and respect the former. The same relationship has not been formed with the **district hospital** where the CHVs must occasionally refer cases from the community. In most cases, the

CHVs are required to refer patients to their WHCs before sending them to the health facility. This is cumbersome and time consuming. It would be more efficient and effective to involve the district health facility more in the MHPP. First, the Civil Surgeon who is responsible for the district facility is fully oriented and should be fully briefed on the program. S/he should be intimately familiar with the program since the Civil Surgeon is a member of the Municipal Essential Service Package Coordinating Committee (MESPCC). But typically the staff of the hospital is not aware of the program or the role and responsibilities of the CHVs. Once the introduction has been made, the CHVs should be given a book of referral slips to be used to send patients from the zone to the district facility.

**Recommendation #5:** The staff of the district hospital in each MHPP municipality should be familiarized with and oriented on the program's objective, the WHCs and their community volunteers and CBAs.

**Recommendation #6:** CHVs and the CBAs should be given books of referral slips so they can refer sick community members directly to the district hospital.

◆ Immunization – Another component of C-IMCI is immunization. Coverage rates of under-ones with basic childhood immunizations before the age of one are generally high in Bangladesh. According to the 2004 BDHS, 73% of the children between 12-23 months had received all their basic immunizations (either health card or mother's report). The rate was almost 81% in the urban areas of the country and 76% in Rajshahi Division. The MHPP **coverage** figure includes both those with vaccination cards as well as mother's report. It went from an already high 82% in the baseline KPC to an impressive 90% in the most recent survey, higher than the national figures. Two-thirds to three-quarters of the children have vaccination cards. If you consider only those with cards, the overall coverage rate for the MHPP municipalities is over 76%.

Recently **Hepatitis B** vaccine (three doses) was added to the regime. Performance in the uptake of this new immunization has been impressive as well – increasing from 17% in the baseline to 93% in the mid-term KPC. This sharp increase is responsible for most of the overall increase in complete immunization coverage in the MHPP municipalities.

Performance by municipality varied from 82% in Nilphamari to 94% in Bogra. When complete immunization coverage rates are disaggregated by gender, the rate for males and females are not significantly different (89.9% and 89.6%, respectively). As would be expected, rates vary according to the education of the mother – from 82% for those with no education to 93% with secondary education. In addition, coverage rates are directly correlated with income, increasing from 83% in the lowest asset quintile to 97% in the highest. Concern Worldwide has focused considerable attention on reaching the poorest segment of the society through its Least Advantaged Group (LAG) effort which will be described in greater depth in the sub-section below on Capacity-Building – Community/Ward.

These vaccination results have been achieved as a result of two different interventions. One is the organization of the wards and the **mobilization** of individual households to ensure that they have their children immunized. If families resist the efforts of their CHV, other community members from the local religious leader (most often an Imam), to the commissioner, who heads the Ward Health Committee, visit the household to explain why childhood vaccinations are essential to protect their child's life. If a child does not show up for their immunization, the CHV responsible for that household goes to the family and reminds them of the need for vaccination and, if necessary, escorts the child to the health facility to receive the required vaccination(s).

On the supply side, the **Municipal Health Department** (MHD) staff members are given a three-day course on all the components of a successful immunization program, including registration and target fixing, use and safe disposal of non-reusable syringes, cold chain maintenance, vaccine administration, counseling of caretakers on side effects. The quality-management checklist is utilized monthly to monitor performance at both the fixed and outreach centers.

### **c. Nutrition and Micronutrients (20% of LOE)**

Bangladesh has a chronic and severe malnutrition problem. No health intervention can be considered without including a nutrition component. The situation in the seven municipalities in the MHPP is no exception. The prevalence of **underweight** (minus two standard deviations) was a high 38% in the baseline survey and stands at 36% in the 2007 KPC. The rate of severe malnutrition is almost 8% with moderate accounting for another 28%. Nilphamari had the highest rates of both severe (12%) as well as moderate (37%), meaning that almost half of their under-five population is significantly underweight.

MHPP's nutrition intervention does not include **growth monitoring**. This would allow the project to identify those most severely malnourished and target them for special support through their LAG effort. It could even be the basis for a Positive Deviant strategy. However, the review team did not consider it worthwhile for the project to get involved in trying to introduce such an intervention since it would further over-burden human and financial resources.

◆ *Breastfeeding* - MHPP depends on **nutrition advice** from its corps of volunteers and CBAs to raise awareness and change behaviors of the community. It starts with educating pregnant mothers on the need to start breastfeeding their newborns within the first hour of delivery. This includes the giving of colostrum with all its immunological benefits to the infant. This is contrary to traditional habits but even steadfast opponents like the mother-in-law can be overcome through the communications and behavior change capacities of CHVs and CBAs. MHPP was able to achieve a 10% improvement in the percentage of mothers breastfeeding their newborn **within the first hour** – from 40% to 44%. This is double the rate reported by the BDHS in 2004 for the country. The highest rate in the MHPP is found in Gaibandha (55%) and the lowest in Dinajpur (35%).

The change agents at the community level also stress the importance of **exclusive breastfeeding** and the introduction of complementary food at six months. The percentage of mothers practicing exclusive breastfeeding was found to be slightly less than 66%, virtually the same as reported in the baseline. In the very important aspect of **complementary feeding** of 6-11 month old children with at least three foods during the last 24 hours, there was virtually no change. Because experience and research demonstrates that this one behavior can have the greatest impact on a child's nutritional status, more attention to this aspect is required.

◆ *Vitamin A Supplementation* – Vitamin A coverage of **under-fives** (as measured in the 12-23 month olds) was increased by almost 24% since the launching of the MHPP in the seven municipalities. While 73% coverage is respectable, the community volunteers and members interviewed by the MTR team insisted that they had achieved universal coverage. They are certainly aware of the benefits of vitamin A supplementation and have promoted the intervention among the population for whom they are responsible, but occasional supply problems seem to have prevented complete coverage. There was also widespread knowledge about the need to give postpartum mothers a vitamin A supplement after delivery. Despite this support and advocacy for this micronutrient intervention, coverage has not reached 40% of the target population. Once again, stock outages can be blamed for at least a portion of the problem.

**Recommendation #7:** Efforts should be made to identify the root cause of the logistic supply problems that result in shortages of vitamin A and as solution found.

There was hardly any difference in the coverage rates by **gender** of the child, education of the mother and asset quintile. This is encouraging and suggests that the MHPP has done a good job in ensuring access to the entire community. However, some difference was observed among the municipalities. Bogra had the lowest coverage rate (55%) and Joypurhat had the highest at 85%.

## **B. Capacity Building – Municipality**

While the technical/health-related results achieved in the first half of the MHPP were good, it is the process aspect that was especially important. As was the case in the CSP, Concern Worldwide's strategy of building capacity at the municipal and ward levels is central to achieving project objectives in the MHPP. It is based on the 1995 MOLGRD&C circular that mandated the establishment of health committees at both levels. The municipal body is referred to as the Municipal Essential Services Package Coordination Committee (**MESPCC**). It is headed by a Chairman and is composed of commissioners from all the wards of the municipality plus other stakeholders who are directly involved in health service delivery (e.g., Civil Surgeon or his/her representative, Deputy Director for Family Planning or representative, head of the Municipal Health Department, Deputy Director of the Islamic Foundation, district-level authorities of the Social Welfare Department, Women's Affairs and Primary Education Department, NGO

representatives)<sup>6</sup>. It is supposed to meet quarterly. Concern Worldwide took the concept and paper policy and put it into practice.

As discovered in the CSP and other projects, nothing is possible without **community involvement**. It is equally true that anything is possible if the community is properly oriented, organized and mobilized. The importance of the municipal coordinating body is increased when the sustainability of the urban community-based health intervention is considered.

Concern Worldwide invests heavily in the training of the municipal authorities in the seven MHPP municipalities. The training of the municipal **cabinet** (consisting of the chairman and the ward commissioners and Secretary of Municipality) is intense. It takes a total of 13 days, divided into four sessions (3 days on the role and responsibilities of the cabinet members and review of the statutory duties and operational mechanisms of the health program; 2 days on priority basic maternal and child health messages; 3 days devoted to the concept and elements of participatory planning and how to develop and monitor a participatory action plan; and 5 days on local level advocacy and policy formation. This was practiced in CSP while in MHPP the 13-day training of municipal cabinets was condensed into three days (1.5 days in-house session and 1.5 days in community visit sessions).

In the MHPP, there is no formal training of the **MESPCC**. A majority of its members (i.e., all the commissioners and the chairman) received the in-depth training since they belong to the cabinet. There is an orientation of the members and technical briefings by the two technical members of the group, i.e., the Civil Surgeon and the Deputy Director of Family Planning.

#### **Box #4 – Chairman (Dinajpur)**

*I first thought of the [MHPP] program in terms of tangibles such as clinics or ambulances. It took me some time to shift my paradigm and understand it is primarily a capacity-building effort. Now I am committed to MHPP and leading the effort in Dinajpur.*

One important change from the CSP is that instead of MHPP doing all the training of the CHVs and the WHCs, the **MHD** receive training as trainers (**TOT**) and conduct the training. Not only does this reduce the heavy training burden on MHPP, but it also gives the local municipal health staff the capacity to train any future groups of replacement CHVs and conduct refresher training. This is important especially when considering the sustainability of the urban health program.

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<sup>6</sup> It should be mentioned here that the municipal commissioners and district authorities of Islamic Foundation, Social Welfare, Women Affair and Primary Education were not mentioned as member of this committee in the revised circular of 2002. The MESPCCs considered them important and co-opted them as members

**1) Results:** An important part of Concern Worldwide's attention to capacity building is the means to monitor the process. This helps make a "soft", rather amorphous and ambiguous, concept easier to grasp by breaking it into its component parts. The primary tool used in the MHPP to track the capacity of the MESPCCs is the Health Institutional Capacity Assessment Process (**HICAP**) which was developed and used successfully in the CSP. The HICAP focuses on five important elements required for effective organization. By assessing the municipality's capabilities in these five aspects, with the help of a facilitator, the group is able to determine their progress and identify the aspect(s) where they must strengthen themselves if they are to improve their score. In other words, it turns something very abstract into something more tangible, comprehensible and measurable.

The five components of the HICAP are Human Resources Supervision and Development, Leadership, Planning and Implementation, External Coordination and Local Resource Mobilization, and Monitoring and Evaluation. Each of these elements has anywhere from three to five indicators to help measure progress or lack thereof.

In the MHPP, once the MESPCCs had been activated and oriented, a HICAP was conducted in 2005 and 2006 in all seven MHPP municipalities. As would be expected, the scores were low – ranging from a 1.66 in Nilpharmari to a 3.31 in Joypurhat. A follow-up HICAP was scheduled for earlier this year to determine how well the municipalities were doing, but it had to be postponed due to the political situation. It is now scheduled to be carried out in year 4 (2008). Only then will the project be able to determine the effectiveness of the new capacity training strategy at the municipal level.

**Recommendation #8:** The follow-up HICAP should be conducted as soon as possible to determine progress in the individual municipality's capacity and in what aspect(s) they require strengthening.

In addition to the HICAP, the MHPP monitors **other important activities** for which the municipalities are responsible. For example, a variety of activities are monitored, including: the number of times the MESPCC conduct their quarterly meeting, number of members attending, meeting reports submitted to MOLGRD&C, development of annual action plans, monthly meetings with the MHD, number of members participating in technical update sessions. The performance in such activities since the beginning of the MHPP has been mixed. Slightly less than half of the MESPCC quarterly meetings have been held and attendance at those meetings was 32%.

**2) Findings:** The review team was informed that the primary reason for the shortfall in performance by the MESPCCs was the unsettled **political situation** dating back to October 2006. Since January 2007, it has been difficult to work with the Municipal Chairmen as two have been jailed and several others in hiding as a result of crack downs from the interim government. This has seriously disrupted the operation of the MESPCCs.

◆ Local Leadership - The political upheaval and disruption have accentuated the importance of local leadership. While some municipalities have effective panel chairs, in a few cabinets there is a vacuum which causes uncertainty and it takes time to sort out. Those familiar with local power structures and politics explain that Chairmen are often concerned that panel chair might challenge his political power and eventually unsettle him. Nonetheless, the problem exists and requires attention since leadership is apparently the most essential component in determining the effectiveness, particularly of the MESPCC. To date, the MOLGRD&C has not addressed the MESPCC leadership issue which is necessary to help ensure continuity of municipal-level activities.

**Box #5 – Municipal Health Department Worker (Kurigram)**

*[After MHPP ends] the WHC will work; we can all work. But if the Commissioner does not drive the car, it will not run. Without leadership in the WHC, it will falter. We have to have a mechanism to ensure that the WHC will keep going.*

**Recommendation #9:** The MOLGRD&C should strengthen the system to ensure that acting chairmen and commissioners have the authority they require to function effectively.

◆ Dhaka Coordination - As the municipal health strategy developed by Concern Worldwide matures, there is a growing need for changes at the top involving the MOLGRD&C. The CSP and now the MHPP has demonstrated how effective local capacity building and organization can be, but if this is to be sustained and replicated on a larger scale elsewhere in Bangladesh, it is time that the MOLGR&DC become involved. Concern Worldwide has begun to make some strides in increasing the **Ministry's participation** by exposing key officials to the Learning Center and identifying a champion to advocate for the approach. But more is required.

The 1995 circular that established the WHCs and MESPCCs also mentioned that there should be an **Inter-Ministerial Coordinating Committee (IMCC)**. This existed in the past – in the late 1990s under BASICS I and the IOCH Project for urban EPI. When the project ended the IMCC became dormant. It has a vital role to play in taking the urban health model developed by Concern Worldwide to the next level. The IMCC if the approach is to be sustained in the municipalities where it has been introduced and expanded to additional municipalities. It is important that the MOLGRD&C has someone designated for urban health. The IMCC may be expanded to include other relevant stakeholders in urban health.

**Recommendation #10:** Concern Worldwide should advocate and facilitate the activation of an Inter-Ministerial Coordinating Committee. They should orient its members and develop its initial action plans.

◆ Central Capacity Building - To make this happen and to provide greater support for the sustainability and expansion of the urban health model, Concern Worldwide requires a full-time person based in Dhaka who is person responsible for increasing MOLGRD

involvement and support. The DIP included a position (at three-quarters time) entitled Advocacy Adviser. Despite considerable effort the position was never filled. The description of this position's key roles and responsibilities was: "policy research; networking; urban coalition partnerships; advocacy strategy development and oversight". It should include more direct liaison and capacity-building at the ministry level. Among the tasks of this **National Promotion/Liaison Officer** would be to take the lessons learned at the field level and ensure that they are understood and addressed at the national level.

One example is the authorization of the alternate leader that is referred to above. Another role would be to interact with the Urban Primary Health Care Project-2 (UPHCP-2), funded by the Asian Development Bank (ADB). This project operates in the six City Corporations and five municipalities, including Bogra which is one of the MHPP sites.

**Recommendation #11:** Concern Worldwide should add a National Promotion/Liaison Officer to its MHPP staff in Dhaka. His/her responsibility would be to build capacity and develop a support structure at the MOLGRD&C to help sustain and expand the urban health model that is being implemented in the MHPP.

A **Project Advisory Committee (PAC)** was formed to support the MHPP but it has only met a few times and is not even as an effective body. It would be worthwhile for Concern Worldwide Bangladesh and the MHPP to consider revitalizing the PAC and having it play a more influential role in the last two years of the project.

◆ ***Health Staffing – Deficient staffing*** is a problem at virtually all urban health facilities in every municipality. Regardless of whether it is the MHD or the MCWC or the district hospital, the most common complaint is that they don't have enough health workers to provide adequate services to the population. This problem is mentioned in the above subsection in relation to MCWCs and how it affects ANC coverage. Every MHD the mid-tern review team spoke to emphasized that the lack of staff limited the quantity and quality of services they can provide. District hospitals are no different.

The problem is particularly acute at the MHDs (see **Table 3**). Their staff is typically limited to approximately a dozen functionaries. Less than half of the approved positions are filled. Rangpur is the worse with 22% and Nilphamari is not much better with 33%. Staffers are demoralized. They have no scope for advancement and little access to increasing their salaries through "alternative sources". In many cases, MHD staff members join the tax department which involves greater earning potential. When a Chairman or MESPPC decide to add several persons to the MHD and make a request to the MOLGRD&C for approval, the request is held up and unreasonable demands made. Staffing is a matter that requires serious **attention at the central level** and is something that the IMCC should consider and that the Concern national promotion/liaison officer should pursue.

**Table 3**  
**Municipal Health Department Staff Status**

Municipality	Sanctioned/Approved Posts	Presently Deployed/ Operational Staff
Bogra	33	12
Dinajpur	28	11
Gaibandha	28	12
Joypurhat	28	13
Kurigram	28	11
Nilphamari	18	6
Rangpur	162	36

**Recommendation #12:** Staffing deficiencies should be considered at the MOLGRD&C and MOH levels to ensure that the urban health model is implemented properly/ effectively and that the demand generated through community involvement is satisfactorily responded to.

◆ *Municipal Finances* – According to municipal chairmen interviewed, health was not included on cabinet meeting agendas prior to MHPP. Now they discuss health issues, coordinate with the various stakeholders and allocate more resources for health activities. In most cases, the largest item in a municipal health budget is for garbage collection. But gradually other activities are being included and additional funds budgeted. It is unclear how health budgets are calculated because it is hard to understand how a larger municipality like Bogra can budget TK600,000 (less than US\$9,000) while Gaibandha, a municipality less than half the size, allocates four times as much. But when the amounts for health in 2005-6 are compared to that for 2006-7, five of the seven MHPP municipalities have increased their health budgets significantly (Bogra by 91%, Dinajpur by 54%, Gaibandha by 21%, Joypurhat by 8% and Rangpur by 69%). Nilphamari endorsed the WHCs by allocating TK 10,000 (almost US\$150) to each of its nine WHCs for health-related emergencies.

◆ *Imam Involvement* – One of the important participants at the municipal and ward levels is the Imams. Those that receive MHPP training are effective advocates and change agents. On occasion, they include health messages in their Friday prayers. And when community members come to them expecting to be healed by some blessed water or prayer, the Imams advise them that spiritual help is not sufficient and that they should seek health care. To date only a portion (maybe 50% to 60%) of the Imams have received training. The Imams themselves as well as community members think that **all Imams** should be familiar with the health program and should receive training.

The MHPP is quite overwhelmed by project **capacity building** needs. To respond to the felt need to train all the Imams in the project municipalities, several Imams should be trained as trainers so that they can orient and train their colleagues. These same individuals would also be able to carry out periodic refresher training for all the imams.

**Recommendation #13:** Concern Worldwide should train several trainers in each municipality and they should train all Imams and other religious leaders (e.g., Hindu Purohits) in their respective urban centers.

The MHPP are to be commended for developing a training curriculum and materials for and including the Hindu religious leaders, the **Purohits**, in the program. This will provide the communities that are predominately Hindu with influence and promotion that was heretofore missing.

◆ *Bogra* – The municipality of Bogra is growing very fast. It is a thriving business center and has recently made the decision to expand into territory surrounding the existing city, adding **another nine wards** to the current 12. The Bogra Chairman has requested Concern Worldwide to establish the MHPP infrastructure and build capacity in the nine new wards. With numerous demands on its time and limited resources, MHPP is not eager to take on this additional responsibility/obligation.

Despite MHPP's hesitancy, there are those who see an **opportunity** in Bogra beyond MHPP. With the UPHCP-2 being implemented in the municipality, there is a chance for MHPP to learn more about UPHCP-2 and to establish a closer working relationship with them. With its generous funding and the need (may or may not be perceived) to establish a closer relationship with the community, UPHCP-2 may be interested in partnering with MHPP. Discussions should take place at both the Bogra as well as Dhaka level. This would be a most appropriate matter for MHPP's national promotion/liaison officer to pursue. Linking with the UPHCP-2 could be extremely important for the future of the Concern Worldwide urban health activity. It would be a very important way that the MHPP model to be replicated/expanded so that it reaches a significantly greater portion of the Bangladesh population.

Concern Worldwide has started a **costing study** associated with the community-based urban health program. As part of the MTR, Concern Worldwide also started unit cost analysis of the MHPP activities which is divided into two parts. The first part examines and provides costs associated with the establishment of the structure, including all capacity building involved. The second component focuses on the recurrent or operating costs, the funding required to maintain the structure and the program. This includes things like training of replacement CHVs, refresher training and the holding of special events in the community to maintain awareness and enthusiasm for health issues.

These **reports** are expected to be completed and available in the near future. The information for these reports will be useful when discussing and planning for the expansion, replication and sustainability of the MHPP approach. Whether it is with the MOLGRD&C or NPHCP-2, Concern Worldwide will have the information readily available.

**Recommendation #14:** Concern Worldwide should establish links with the UPHCP-2 and determine the most effective way for the two projects to work together to improve health status through community capacity building in the municipalities of Bangladesh.

## C. Capacity-Building – Community/Ward

While the municipal level capacity is essential to the effectiveness of the urban health model, the community level is equally or even more important. It is here that the felt needs of the community are expressed and awareness of basic health practices raised and behaviors improved. The mid-term review team was impressed by what they saw at the community level, with the CHVs and CBAs almost without exception being active and committed volunteers. It is the 1995-initiated WHC that is the organizing body that brings these existing human resources together and provides them with the structure and support that makes them effective.

The MHPP objective is to develop and activate an organization at the ward level and build its capacities to manage and sustain health activities involving a number of key partners. The WHCs, headed by a commissioner, include the woman commissioner<sup>7</sup>, a representative of the CHVs and one for the CBAs, an Imam, a school teacher, one of the MHD (assigned to that ward) and several prominent community members (e.g., retired person, businessmen).

Capacity building at the community level includes a 2-day training course on role and responsibilities of WHC and its members, functions of WHC, orientation on basic health promotion for WHC members. Another 2-day session for WHC office holders focuses on leadership, institutional development, resource mobilization office management and planning. Other **trainings** are carried out for individuals involved in community promotion activities, the CHVs and Imams. The CHVs receive three days of training. In addition to the Imams, Hindu religious leader (Purohits), will be trained in Dinajpur where there is a large Hindu community. The CBAs receive 18 days of training at the local MCWC<sup>8</sup>. PPs/RMPs and teachers were supposed to be trained but this has not been completed yet due to a very heavy load of training. Homeopaths are also a favorite source of medical attention when young children become ill. Concern found that approximately 20% of all cases of ARI and diarrhea, particularly for children under one year old, are treated by homeopaths. This is particularly common in the rural areas, resulting in a plan to train homeopath PPs in Kurigram and Nilpharmari which are smaller municipalities. To date, a large number of community members have received training as shown in Table 4.

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<sup>7</sup> One woman commission is selected for every three wards.

<sup>8</sup> The LAMB Hospital was extremely helpful in developing the training curriculum and supporting the CBA training. Their participation was crucial during the CSP and they continue to be very important to the MHPP updating the national CBA curriculum.

**Table 4**  
**Number of Trained Community Members**  
**(as of April 2007)**

Community Members	Target #	Trained	
		#	%
CHVs	3,600	2,960	82%
Religious leaders (Imams and Purohits)	450	332	72%
PPs/RMPs (including)	225	20	9%
Homeopaths	150	-	-
Teachers	136	-	-
CBAAs	108	108	100%
<b>Total</b>	<b>4,669</b>	<b>3,420</b>	<b>73.2%</b>

**1) Results:** The health indicators discussed above are one demonstration that the WHCs and the community volunteers can, and have made a significant contribution to improved health at the grassroots level. As a result of MHPP capacity-building efforts, the WHCs are able to manage a number of local change agents and achieve a degree of independence after developing organizational capabilities and health knowledge and skills. As in the case of the MESPCCs, the project introduced a means to determine and monitor organizational effectiveness and strengths of the WHCs. This enables the commissioners and WHC members to appreciate the progress they have made and where they have to strengthen themselves to become a viable organization. They are able to conceptualize and appreciate what makes a good organization by understanding the components of the **WHC capacity assessment** tool.

It has taken considerable time for the training of the WHC and its members. As can be seen in Table 4, the job has not been completed. The result is that only recently have the WHCs undertaken the capacity assessment exercise. There was less range in the results than was the case for the municipal cabinets. Kurigram had the lowest score (2.0) and Dinajpur and Joypurhat had the highest (2.7). There is still plenty of room for improvement. The next WHC capacity assessment is expected next year and it will give the communities as well as MHPP a clearer idea of the strengths and weaknesses of the community groups as a whole as well as of each of the 75 individual WHCs in the seven municipalities and the 24 in the Learning Center.

**2) Findings:** Several of the topics discussed in the MESPCC sub-section also apply to the community/ward level as well. In particular, the need to appoint an alternate leader has been amply demonstrated during the political uncertainty of the past year. A significant number of commissioners have either been arrested or are in hiding to avoid arrest. In many cases the Member Secretary has stepped in to assume **leadership** responsibilities although there are no prescribed guidelines as to what should be done and who should be in charge.

◆ CHVs – The final evaluation of the CSP made a point of the low dropout rate among this young cadre of females and males. After starting at over 20% dropout in the first year of the project, the **turnover rate** came down significantly to 8.6% in the final year.

This was considered quite low and certainly understandable since it is to be expected that men and women of this age would migrate out of the community because of marriage, education or employment. A similar situation is found in the MHPP sites.

In the municipalities visited by the MTR team, between 10% and 15% of the original group have moved on. The reason for leaving the project was never because of dissatisfaction with the MHPP or the community work. Nor did it significantly disrupt the implementation of the MHPP. In most cases the departing CHV was replaced almost immediately with a friend or even family member who was already familiar with the program and the roles and responsibilities of a CHV. Nonetheless, it is important that the new CHVs undergo **formal training** to ensure they are fully knowledgeable about the various health activities, especially on technical matters. A number of the MHD staff have been trained as trainers and can conduct the CHV training. Based on the lessons on the Learning Center municipalities, the training of these new recruits must be seen as complete and effective as the training received by the original CHVs. If not the new CHVs will not have the credibility, legitimacy or respect as their predecessors. In order to give the new CHVs proper standing in the community, they must be given an official looking certificate and have a proper graduating ceremony. The community takes note of these details and react negatively if they are not there. Moreover, the training of the replacement CHVs should take place as soon as possible since they will not be legitimate in the eyes of the community until and unless they are formally trained.

**Recommendation #15:** The training of new CHVs to replace ones that have dropped out should be done formally by the trained MHD staff as soon as possible and include formal details such as certificates and graduation ceremonies.

◆ *Least Advantaged Group (LAG)* – The CSP final evaluation found that the LAG members were not being covered as well as other members of the community. LAG households were not familiar with the health program and had not been visited by the CHV. It was recommended that **more attention** be put on identifying and ensuring that the LAG are included in the urban health program.

The mid-term review team found that the LAG have been included to a much greater extent in the MHPP. This has been accomplished through the introduction of a more **systematic approach**. WHCs now make a list of the most disadvantaged households among their population. Each CHV is given the names of the LAGs residing in their zone. This enables them to give them special attention.

All the WHCs that were visited mentioned listing the **LAG households** and expressed the desire to generate resources so that they could assist these poor families cover health costs when the need arose. In addition, when the mid-term review team randomly selected several LAG households for interviews, they not only knew the name of their CHV, but they were also familiar with others in the MHPP in their ward (e.g., the CBA).

The increased involvement of the most marginalized members of the community is bound to have a positive impact on project results. As the KPC has demonstrated, the poorest

quintile experience a **disproportionate share** of the health-related problems and invariably score the lowest. By targeting them and raising their health awareness while changing/improving their health practices, key program indicators should be boosted.

According to Concern Worldwide's **Equity Analysis**, it was determined poor women participating in the MHPP were:

- 1.6 times more likely to receive iron folate during pregnancy
- 1.3 times more likely to consume more food during pregnancy
- 1.2 times more likely to be delivered by a skilled attendant
- 1.8 times more likely that their child will receive vitamin A supplement
- 1.38 times more likely to provide adequate complementary foods to their 6-11 month old child
- 3.45 times more likely to seek appropriate treatment for a child having pneumonia

#### **Box #6 – CHV Saves Life (Dinajpur)**

*Salma was 17 and married to a garment worker who had a job in Dhaka. She lived with her parents in a slum. A Traditional Birth Attendant delivered her baby but Selma suffered from a retained placenta; she started to bleed profusely and went into shock. Yasin, the CHV in the neighborhood, was informed of the situation and, upon seeing the unconscious Selma, went into action. He found a rickshaw van but no driver so he pulled it to the Sadar (Central) Hospital himself. A laparotomy was performed to extract the placenta, but Selma was in desperate need of a blood transfusion. Since the hospital did not have a functional blood bank, Yasin communicated the problem with the ward Commissioner, Ahmeduzzaman Dablu, and organized a blood drive. Having already registered the blood types of the ward community members, Yasin was able to find 13 donors (himself being the first) in a short period of time. Members of the WHC visited her in the hospital to provide her social support. The Commissioner and some influential members of the community met with hospital administrators to ensure Selma received the best care possible and negotiated a reduction in hospital charges. The WHC collected funds to cover the TK.3000 (US\$44) fee incurred by Selma during her 14-day stay. The WHC continues to provide support to Selma and her child. Yasin's good work has been appreciated by the community and demonstrated the value of having a health resource living with the community.*

One obvious way of assisting the LAG would be for the MHPP through the WHCs to link the poorest families with **income generating** opportunities. Most municipalities would have a branch of BRAC and/or Grameen Bank which might be able to help the poor families break the cycle of poverty. It is understood that this is very difficult and challenging with most micro-finance groups saying that they exclude the very poor since it is not possible to help them. However, the MTR team believes that the community-based MHPP could provide the chance and the WHC the support that could help at least a few of the neediest households make a little economic progress and, consequently, improve their health and nutritional status.

◆ **HMIS**: Concern Worldwide worked with **ICDDR,B** in the CSP to design an HMIS for the urban health program. The original design was to be implemented by the MHDs and the MHPP considered this to be inappropriate and doomed to failure. It was constructed around a bulky register that was not only difficult to use but was expensive (TK550 or over US\$8 apiece). That made it highly unlikely to be sustained. The MTR team agrees since the MHD is usually weak and severely constrained by lack of human resources. Under MHPP, a new HMIS was designed and is more appropriate, implementable and sustainable. The register for the new HMIS is much simpler, less cumbersome and costs only about TK150 or US\$2.

The **new HMIS** has been introduced in two wards in each of the seven municipalities. It takes time for the CHV to register each family in her/his zone consisting of 40 to 50 households – usually around 12-15 hours. Most would devote a few hours a day over a period of week to accomplish this task. The next step was the consolidation of the individual household data to compile a ward profile. This would be done by all the CHVs at the WHC level with the school teacher and/or MHD staff member. This took another few hours to compile and record all the data from 1,000 to 1,500 households and 5,000 to 7,500 people.

Despite the work involved, the WHCs and CHVs **strongly supported** the new HMIS. Without exception, the WHCs and the community volunteers in the wards having the new HMIS valued it and found it invaluable for decision making. It gave them a clear picture of the community's health status and allowed them to track progress as well as identify areas that required attention. It translated concepts and lessons into practical, real terms.

The MHPP managers are eager to introduce the HMIS in all WHCs of the seven municipalities. But one concern is the **additional training** it will entail. For the 3,600 CHVs already trained, an additional day of training specific to the HMIS will be required. Assuming approximately 30 per batch, this would require an estimated 120 days or slightly less than 6 months of training. This would place an intolerable burden on MHPP at a time when there are so many other priorities. One suggestion was that MHPP train the **WHC teacher members** and give them the responsibility of training the CHVs in his WHC on how to establish and maintain the HMIS. The project has used cascade training effectively in other cases and this should not be an exception. At the same time, the teachers involvement would increase his interest in the HMIS and would help ensure their continued support for its operation in the future.

**Recommendation #16:** MHPP should train the teachers sitting on the WHC as HMIS trainers in the near future so that they can train the CHVs in their WHCs and launch the new system before the end of the year.

The Medical Officers from the MCWCs were trained to conduct verbal neonatal and infant death autopsies. All CBAs were oriented on **verbal neonatal and infant death autopsy** while attending training at the MCWCs. This will be coupled with the HMIS to explain why the death occurred and how similar deaths can be prevented in the future. This will help the MHPP to include mortality data in its final evaluation.

◆ *Sustainability*: This is a major concern when one considers the future of the urban health approach as designed and implemented by Concern Worldwide. While the strategy has proven successful and improved health status at the community level, it has not been proven yet that the results and the structure that has been put in place can be sustained. The review team believes that there is a good chance that the ward-level activities will continue for some time, but a problem may arise at the MESPCC and municipal level. If the recommendation to increase support for the urban health approach at the central/MOLGRD&C level is realized, the chances for sustaining the municipal level activities would increase significantly.

But something can be learned about challenges that might hamper sustainability from performance in the **Learning Center** (LC). This center has been invaluable in making the urban health approach real and tangible to the Chairman and cabinet members from the MHPP municipalities. But in addition, the LC has also been a laboratory where we can study problems that can be expected to affect negatively the effectiveness of the model after the withdrawal of outside support.

**Box #7– Learning Center Makes It Real for WHC Commissioner (Dinajpur, Ward 11)**

*Our learning Center visit influenced our work... by physically going there and talking to the community stakeholders, I understood better how the WHC should work. Now I feel well educated in MHPP.*

The **mid-term KPC**, a site visit by the review team and discussions with the chairmen from the two municipalities confirm that there have been problems. KPC results for the LC are given in Table 3.

**Table 5**  
**Intervention Outcomes in Learning Center Municipalities (Saidpur and Parbatipur)**  
**(CSP Endline Survey, 2004 vs. Mid-Term KPC)**

Indicator	Endline (2004)	Mid-Term KPC
<b>I. Child Health</b>		
Immunization (12-23 months)	91%	90%
ARI – seek treatment	34%	68%
Diarrhea – seek treatment	24%	45%
Underweight (-2SD)	28%	45%
<b>II. Pregnancy</b>		
ANC – 3 or more visits	65%	62%
Iron supplementation (90 days)	61%	55%
More food than usual in pregnancy	33%	37%
Birth preparation	18%	27%
Delivery in health facility	44%	50%
Vitamin A postpartum	53%	43%

<b>III. Newborn Care</b>		
Breastfeeding initiation (within 1 <sup>st</sup> hour)	58%	53%
Complementary food (6-11 months)	82%	62%

While the outcomes in the final CSP KPC were strongly positive, the results of the recent KPC are mixed. Some of the indicators continue to show improvement, namely immunization which remains very high, treatment of ARI, iron supplementation during ANC, increased consumption of food during pregnancy and delivery in health facility. However, several indicators show a **decrease** in proper health practices. For example, care seeking treatment for diarrhea, ANC visits, postpartum vitamin A supplementation, early breastfeeding initiation and the feeding of complementary food at six months all decreased while malnutrition increased.

It is difficult to identify exactly what transpired in the two LC municipalities. It seems that there has been a slow but perceptible decrease in enthusiasm and energy on everyone's part. It is like a battery **running down**. It needs a charge, to be reenergized. In addition to the problem with the training of the new CHVs, those associated with the LC municipalities mentioned that the spirit that was present under CSP no longer exists. According to them, one of the things that was missing was the **special events** that were held at least four times a year. Observations for World Health Day, World Breastfeeding Day, Safe Motherhood Day, World AIDS Day were not held in the last several years without project support and organizational initiative. They functions included things like a prize for the best father which motivated as well as educated the community.

Based on the evidence, the MTR team suggests more attention must be given during the last two years of the project to address sustainability of the urban health strategy that has been implemented in the CSP and MHPP. The project must identify the most essential ingredients required to sustain the strategy and list them in a **Phase Over Package (POP)** complete with guidelines on what local communities must do to sustain the approach once they are on their own. Experience shows that the strategy cannot be phased over abruptly – rather it has to be done consciously and strategically with a gradual handing over of responsibilities to the municipalities that will be expected to manage the approach once Concern Worldwide is no longer involved. It would be preferable if the municipalities had full control over the process for the final year of MHPP so that the MHPP management and technical staff can provide them technical assistance and support them if they face challenges that they cannot deal with on their own.

One component of the POP will be the **Operational Manual** for Strengthening Urban Health Systems which the MHPP staff is in the process of drafting. It will consist of eight chapters: urban health situation; MHPP model; building partnership with local government; health system strengthening; community mobilization and linkages with health system; measuring progress; sustainability and phase-over plan; conclusion. The manual will include guidelines, curricula, tools, concrete examples of how the approach is implemented and success stories. In addition, barriers and challenges, and how to overcome them, will be included. It is due to be completed by mid-2008.

**Recommendation #17:** MHPP together with its partners should develop a Phase-Over Package that will guide the transition from project support to self management.

The training of replacement CHVs, refresher training for WHC members (especially CHVs and CBAs), the celebration of special events, the financial needs are all part of what will be included in the POP. The municipalities require a clearer idea on the resources that will be required. They all complain about the lack of funds. While **resources** are scarce, the costs required to keep the health approach as developed under CSP and MHPP does not require significant funding. For example, a special event costs only 2,000 – 5,000 Taka (less than US\$30-75) for a simple banner and snacks. This cost is typically shared by a number of partners (NGO, Deputy Director of Family Welfare, Civil Surgeon) so the municipality has only a small share of the total cost. It appears that taking the initiative for organizing these affairs may be more of a challenge than the cost itself.

MHPP has scheduled in the near future **technical assistance** from a sustainability expert who used to be a member of the CSTS+ staff and is intimately familiar with community-based Child Survival projects. His consultancy should be very helpful to the push the project's thinking further in this important aspect.

◆ NGO: It was recommended in the CSP final evaluation that an NGO operating in a project municipality be recruited to serve as a partner for the MHPP. The project has been successful in identifying and establishing a working relationship with NGOs in six of the seven new municipalities in the MHPP. There is no NGO with health services or capability operating in Gaibandha. The involved NGOs are all part of the NSDP (NGO Service Delivery Project), funded by USAID/Bangladesh. The **synergy** between MHPP and the NSDP partners is obvious. One of the major objectives of the NSDP is generating income from the provision of health services which means that they must maximize their outreach and recruitment of clients. By working with MHPP, the NGOs are able to reach into the communities and potentially access a new client base. This will help the NGO achieve their objective by increasing their patient load and income. At the same time, the NGO could gradually assume the role of Concern Worldwide and MHPP, providing support and organizational capacity for the MESPPCC.

**Recommendation #18:** MHPP should turn over more facilitation responsibility to the partner NGO during the last year of the MHPP so that the latter can play a more responsible role in the implementation of the urban health program.

#### **D. Cross-Cutting Issues – Training, Behavior Change, Quality of Care and Sustainability**

These cross-cutting issues relate to all three components of the MHPP – health services, municipal authorities and community. All three are extremely important and have been referred to at least to some limited extent in the preceding discussions. However, it is worth addressing each of these themes in greater detail and across the project components.

◆ **Training** – The MHPP has conducted a huge amount of training. The volume was **increased drastically** and dramatically when the community-based urban health approach was expanded by a factor of six. Just the number of CHVs trained increased from slightly over 600 in the CSP to approximately 3,600 in the MHPP. Considering that the CHVs are trained in batches of approximately 30 and course is three days (prior to adding a day for the HMIS), the project has to devote over 16 person months just to build capacity in this one cadre of volunteers. Add to this, the training of the PPs/RMPs, Imams, teachers as well as the orientation of the MESPCC and WHC officers and it is easy to understand why the training has taken longer than expected.

It should also be noted that the MHPP staff has been decreased significantly from what it was in the CSP. The latter had 18 staff to cover a population of 150,000 while the MHPP has 28 staff to cover a total of approximately 1,000,000 (counting the LC). The **ratio of staff member to population** has gone from one to a little over 8,000 to one for over 35,000. This required Concern Worldwide to change the nature of its involvement – from facilitation and implementation in CSP to completely facilitation in MHPP. It is for this reason that the training package is almost completely carried out through TOTs using the cascade training approach. When expanding by a factor of six times, there really is no choice. The quality of the capacity and awareness building does not seem to have suffered despite the significant increase in population covered and the new training methodology.

In an effort to keep the number of staff to a minimum, the DIP calls for the **reduction of one trainer** in the large municipalities in year three. It was planned in this manner assuming that the training would be completed by then. That turns out not to be the case. With all the work that remains to be done, including considerable amount of training, it would be extremely unwise to reduce the number of trainers at this time.

**Recommendation #19:** The DIP should be revised and the training staff at the municipal level along with Training Officer should be kept at current levels.

In scaling-up the urban health approach there is a **tension** between streamlining and routinizing the project and maintaining quality and ability to achieve results. Initial evidence as seen in the follow-up KPC is that Concern Worldwide has done an effective job of streamlining project inputs without losing effectiveness.

The review team noted that the health **service providers** at the MCWCs and in the MHDs were **energized and empowered** by their new role as facilitators and technical support personnel. Being linked intimately with the community for the first time gave their jobs more meaning and their morale improved. The same phenomenon was noted in the CSP.

◆ **Behavior Change Strategy** – The behavior change strategy that was developed in the CSP and is being utilized or has been modified for use in the MHPP is effective to achieve project objectives. It is based on the **BEHAVE framework**, taking into account

the audience, the behavior in question, key factors, activities to ensure behaviors are being followed and indicators to monitor practices to determine extent of change.

MHPP formed an **Inter-Municipality Behavior Change Team (IMBCT)** in early 2006 to improve the effectiveness of project's Behavior Change and Communication (BCC) activities. Each municipality is represented by a small team of four people including the representatives of the Civil Surgeon and Deputy Director-FP, NGO representative, head of the MHD and a WHC member, and the Health Convener (a commissioner). At a 3-day workshop, this 33-member group developed a BCC plan. It meets on a quarterly basis to discuss their specific problems and develop individual municipal-level plans. This IMBCT used the KPC data to inform its decisions and plans.

The MHPP uses **doer/non-doer survey** to develop their BCC messages. They select a cross-section of 25-30 mothers from all socioeconomic groups to determine benefits, disadvantages, who/what supports the behavior, who/what prevents. Some of the topics that have been analyzed are how to increase food intake during pregnancy, to ensure post-natal visits and guarantee women have at least three ANC visits. Based on the results of the exercise, the municipality prepares a BCC plan that is submitted to the MESPCC for approval. The initial meeting is facilitated by the MHPP staff; after that the municipality leads the effort. The unsettled political situation that has disrupted the MESPCC has delayed the approval of the **municipal plans** but the project considers it essential that the municipality have ownership therefore will wait until the process is completed.

#### **Box #8 – Sustainability of Results, Cabinet Meeting (Parbatipur)**

*Health messages to the community have gone down into their hearts so it won't disappear.*

One example of how the process works is Gaibanhda issuing a circular that encourages all mothers to receive vitamin A after delivery and not to give a newborn a bath for the first 72 hours. These behaviors were chosen because they were weak in the recent KPC findings for this particular municipality. All CHVs will get the message and stress it in their interaction with the women in their neighborhood.

#### **◆ Quality of Care**

MHPP program was designed to strengthen the existing infrastructure of health especially in the provision for maternal and child health care services in seven municipalities of Rajshahi Division. The main findings from the quality of care perspective are grouped under four headings – inadequate staffing, child health services, standards and protocols and infection prevention and control.

*- Inadequate staffing and facilities to respond to and satisfy community demands:*

Problems were identified at several levels in the MHPP municipalities. It was most apparent at the **MCWCs**. The typical staff of such a facility was found to consist of two

doctors, usually an obstetrician and an anesthetist, plus four or five Family Health Visitors (FWVs). In several of the project municipalities this was inadequate to meet the demand for ANC and 24-hour EmOC (Emergency Obstetric Care) service. The MCWCs visited by the review team provided ANC for two days a week. Yet the demand from the community was often more than could be serviced. For example, in one municipality only 40 women were seen a day whereas over 100 showed up. This meant that 60 women went home unhappy and frustrated. In addition, the team visited three MCWCs where mother were expectant or recently delivered mother were lying on the floor for lack of sufficient beds.

The **MHDs** in all the MHPP municipalities commented on how they had very limited staff. The departments often consisted of four or five persons, including several vaccinators and a Sanitary Inspector. One of the smaller municipalities in MHPP had only two staff members. The sanctioned positions are significantly higher, approximately 20 to 25. But many of them have left and joined other departments, especially the tax department where the potential to increase income is considered much better. In addition, permission for municipal authorities to hire health workers is often delayed in Dhaka.

Only one of the seven MHPP municipalities has a **Medical Officer** (MOs) and he is due to depart soon to start an MPH program. He was in the municipality that had the UPHCP-2 project and that was sufficiently attractive to provide an incentive for him to spend at least a short time in the municipality. Young physicians are not interested in the municipal Medical Officer (MO) position since there is little or no chance for advancement and the MOLGRD&C has no career path that would attract a doctor starting out his medical career.

Recommendations #10 (relating to the IMCC) and #12 (on increased staffing needs in municipal facilities) address the problems discussed here.

*Quality Child Health services are not available in MCWC:* The review team was concerned by the quality of diagnosis and counseling of sick children practiced at the observed MCWCs. Clinical staff were not using basic equipment such as ARI times, thermometers or stethoscope to examine the child. Further drug dispensing did not follow standards and counseling of caretakers on use of medicines was poor as they neglected to advise on how long to take medicine, danger signs to look for that would indicate need to return, nor possible side effects.

The primary reason for the **lack of quality child health care** is that the providers at the MCWCs have not been trained in IMCI. The regional district medical college has recently received TOT as part of the decentralization plan for training, but it has not begun to train the MCWC staff. Moreover, the MCWC staff has not been oriented on rational drug use.

**Recommendation #20:** MCWC staff should be trained on IMCI to provide quality CH service to the community and efforts should be made to increase their knowledge about rational drug use.

It should be mentioned that the Maternal, Neonatal and Child Technical Coordinator attended a 2-week QoC course at Johns Hopkins during the final year of the CSP. He should take the lead in shaping the QoC component with his **IMCI** counterpart.

- *Standards and protocols are neither available nor being followed at all center:* The review team found that municipal health facilities do not have copies of **national standards** on maternal health, child health, infection prevention practices. The municipal authorities said that there was a lack of resources to print the standards/protocols for all centers.<sup>9</sup> The lack of these standards helps explain the lack of attention to QoC issues. MHPP has planned three workshops on Quality Assurance for later this year, in early Year 4 of MHPP. As an output a team will be formed from the local level which will monitor quality semiannually at the health care centers using the tool. The approach is similar to the one taken by Concern with the self-assessment at a municipal and ward levels. Based on the key points from the workshop, efforts should be given to develop, approve and finalize the tool for QoC

It was noted that the NSDP facilities had a better culture of quality and paid considerably more attention to QoC issues. They have a quality assurance system in place and it is reinforced by regular supportive supervision.

**Recommendation #21:** Concern staff should motivate central-level decision makers to make standards available and use these standards during pre-service training. MHPP should put greater emphasis on the QoC aspect of Maternal and Child Health services being provided at the municipal level..

- *Infection prevention practices, including waste management, is a problem:* Facilities like MCWCs are still using needle crusher which is not according to the standard. In some facilities staff are bending/recapping the needle and keeping used needles and syringes in open containers. In addition, MCWCs do not **segregate waste** or use incinerators to destroy infectious wastes; they just keep the hazardous waste in a covered pit. Containers contaminated with blood and body fluids are often being reused at the facility level without being properly decontaminated. They are just washing the containers under tap water with bare hands.

The review team found that MCWC staff is **not aware** about quality of care and its importance. They have received training on the subject, but they are not complying with the standards because of a lack of accountability (to both supervisor as well as patient). Customers generally are not aware of safety/infection control issues, thus, they do not demand quality care.

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<sup>9</sup> Standards were initially printed by the NGOs and funded by a donor.

**Recommendation #22:** Consider assisting the MOHFW to establish an accreditation mechanism for QoC across their institutions (especially the MCWCs) in which relevant standards can be set or mechanism for voluntary accreditation developed (as done in a number of developed countries).

♦ **Sustainability** – A portion of the sub-section on the community/ward was devoted to this topic. It is such an important issue, especially in the last two years of the MHPP, that it warrants additional attention.

In the CSP final evaluation, the point was made that the predecessor project did not create any **financial dependency** that could impede sustaining the approach. At closer attention, there are a few costs involved if the MESPCCs and the WHCs are to remain trained, motivated and highly active. But these costs are minimal and will be spelled out in some detail in the guidelines to be produced as part of the Phase-Over Package.

Of greater concern, however, is “**process dependency**”. By this is meant that the municipalities and the MESPCC and WHCs come to expect the MHPP and its committed staff to initiate and organize health-related activities (e.g., special events). Without the initiative, the necessary trainings for the newly recruited CHVs, or the refresher training of the CBAs or CHVs, or the regular meetings of the CHVs might not take place. As mentioned in the community/ward sub-section, this is the reason that the involvement of the local NGO is so important.

**Box #9 – Need to Keep Pushing, Cabinet Meeting (Parbatipur)**

*There is a need to keep pushing from the back after Concern is no longer there, especially for logistical support and refresher training.*

People can and will be **skeptical** of the urban health model that Concern Worldwide has developed and now implemented on a large scale. It is an effort that is based almost completely on capacity building and relies heavily on volunteerism. It is difficult to comprehend unless seen in action. As the Chairmen and commissioners said on multiple occasions, “seeing is believing”.

Discussions during the MTR came to the conclusion that Concern Worldwide has accomplished what it set out to demonstrate almost a decade ago. They have shown in the CSP that it is possible to organize and mobilize municipalities and improve the health awareness, behaviors and outcomes. After proving the efficacy of the model and streamlining it for expansion, the MHPP has clearly demonstrated that the approach can be scaled up without losing effectiveness. In addition, there are positive signs that the Concern Worldwide urban health design can be sustained and continue with a high degree of effectiveness after the municipalities have to operate on their own. However, what has not happened to date is the **institutionalization** of the urban health community-based model in the MOLGRD&C. The problems with the Ministry and their lack of support has been mentioned above and Recommendation #11 stipulates, attention must now shift to Dhaka and working on getting Concern Worldwide’s approach accepted and

made the norm for urban health throughout the country. At the end of MHPP, Concern Worldwide will have done as much as it can do; then it will be the responsibility of government and it will be up to them to follow the path that has been blazed and find resources to expand the approach to as many municipalities as possible, if not all. The MOLGRD&C's attitude must shift from "We are here to help you implement the urban health program" to "This is the way we do urban health and it will be done throughout Bangladesh please help us do it". That ownership and institutionalization of the approach is yet to be achieved and Concern Worldwide will have to devote considerable energy to this in the last two years of the project if the model is to have life after MHPP.

♦ **Operations Research (OR)** – Four Operation Research studies were outlined in the DIP. The MTR team followed up on their progress.

- *Post-intervention Sustainability Assessment* – This exercise was meant to collect data from the two CSP municipalities to ascertain if the health benefits were sustained. This was done by means of the MTR KPC that was carried out in early 2007. Concern Worldwide learned that there was some slippage in several of the key indicators and identified reasons for this. They made some adjustments in their approach in the two municipalities and performance during the last two years of the MHPP will determine whether those modifications improve performance.

- *Cost-Effectiveness Study of Scaling-up the Municipal Health Model* – A framework that looks at costs of various program components by municipality has been used to organize costs from a Concern and municipal perspective since project start-up in 2004. The study has been jointly designed by two members of PDED and a consultant from JHU. A discussion with those involved in this exercise at the country level gave the impression that this study has gotten off track a bit. It appears to be dominated by financial details, producing detailed studies with a very large number of pages full of numbers. Based on the volume of information presented, **it is not apparent that the study will provide the basic information that is really needed.** Instead, what is required is to look at and document two sets of costs: 1) what it would cost a donor or MOLGRD&C to establish the urban health infrastructure (i.e., the MESPC and the WHCs), which would include primarily capacity building training of the various persons involved at the municipal and ward levels and 2) what it will cost to keep the operation going once it has been established – e.g., retraining, refresher training, meetings, supervision, special events. This basic cost data will be required when it comes time to discuss with donors the possibility of expanding the model to other municipalities in Bangladesh. If the new central-level MHPP promoter/liaison person is to be effective, the cost data will be a vital component in his/her promotional tool kit. MHPP has begun to calculate the cost to establish a ward and the operating costs once formed. They should take it further to arrive at an estimated cost (based on an average ward size) to carry out the capacity building and start up of a WHC so that planners can roughly calculate what expansion would cost.

**Recommendation #23** – MHPP should review the design of the study and update to ensure that they can calculate the start-up cost for an average-size ward and estimate what

it would cost to maintain the health operations in that same ward for a year. The Dhaka-based Promotion/Liaison Officer will require this type of information for both the MOLGRD&C as well as donors if large-scale expansion is to take place.

*-Indoor Air Pollution* – Concern Worldwide Bangladesh, in cooperation with Winrock International and Loughborough University (UK), piloted the use of improved stoves to reduce exposure to indoor air pollution. This was to be carried out in the Learning Center municipalities. By increasing awareness and behavior change (e.g., cooking outdoors and keeping children away from the fire during cooking), improving stove design as well as ventilation, indoor pollution can be reduced and, in the process, respiratory symptoms in under-fives decreased.

In 2005 and 2007, health data was collected from over 400 primary cooks of households with under-fives including prevalence of respiratory infections and nutritional status. In addition, indoor air quality/pollution (carbon monoxide and particulate matter) was monitored in selected households. The proportion of children who stayed next to their mother while cooking fell from 52% to 29%. The percentage of primary cooks who reported that smoke may increase the risk of pneumonia in children increased from 31% to 82%. The types of fuels, the location of stoves and prevalence of pneumonia in children did not change. Early indications showed an acceptance of improved cooking stoves and a willingness to install chimneys in homes. This intervention has increased awareness of the health risks of indoor smoke and certain measures to reduce pneumonia risk in children have been adopted. The experience should inform the inclusion of environmental health messages in MHPP. A summary document of the study is included as **Attachment IX**.

*- Test of Effective Delivery Systems for Increasing Use of Iron Folic and Postpartum Vitamin A* – This was to be conducted with ICDDR, B. As data in Table 2 demonstrates, iron/folic acid and postpartum vitamin A intake has increased dramatically during the first half of the MHPP. However, no special study has been carried out to date.

## **IV. PROGRAM MANAGEMENT**

According to the guidelines for mid-term evaluation of USAID Child Survival and Health Grants, the PVO's program management is to be reviewed. This includes program oversight and support at all levels, the field, country office and headquarters. Strengths and weaknesses of the management support system are to be identified as they contribute to or hinder program implementation. During the mid-term review individual MHPP staff members representing different levels of the project were interviewed. This cross section of staff gave comprehensive feedback on project management and operations. Overall, the review team found Concern Worldwide's management at all levels to be efficient and effective. MHPP is Concern's Worldwide US's fifth Child Survival Grant and the agency is now familiar and operate in accordance with all aspects of the program. The management components as identified in the USAID guidelines are addressed in this chapter.

## A. Planning

Concern Worldwide is committed to and practices **participatory** planning at all levels of the organization. All stakeholders and partners are included in a substantive way in discussions and negotiations. This is a core value that permeates all aspects of their work as they appreciate that being involved in planning increases the feeling of ownership. This holds true and is practiced in the MHPP in which all municipal authorities and municipal health staff participated in project planning and implementation, giving them that sense of ownership and commitment. This is true for the cabinet and MESPCC at the municipal level down to the community members at the ward level. All have been involved in all aspects of planning as part of the capacity building process (following the principle of learning by doing) in the form of developing their annual plans.

The participatory planning is done at all levels of operation. At the national level, staff were involved in developing a **strategic planning** for the health sector in Concern Worldwide Bangladesh in mid-2006. Their thoughts were solicited regarding what they'd like to see included.

In the MHPP, all municipalities and the project staff participated in the drafting of the **DIP**. This inclusion not only allowed for valuable inputs from the new municipalities and promoted a feeling of ownership, but it also increased transparency and helped orient the new partners to the project and what was going to be entailed. Concern Worldwide Bangladesh has implemented the MHPP based on the DIP.

At the mid-point, the project is **behind schedule**. This is most clearly demonstrated when the training schedule in the DIP is reviewed. According to the plan, all CHVs should have been trained by the end of the second year. However, it took longer than expected to form all the WHCs. That is the first step in a process that includes WHC training and orientation, capacity assessment and CHV selection. In addition, not all the religious leaders, most of the PP/RMP and none of the teachers have been trained. The MHPP team is currently working on developing a training manual for teachers. Despite MHPP not reaching their original training completion schedule, the review team thinks that the strategy developed and implemented by the MHPP makes sense. It is based on the training of trainers (TOT) and cascade training which reduces the burden on the project staff. It is expected that the training will be completed by the end of 2007 or early in 2008. Capacity assessment reviews at the municipal level are also late. They were scheduled for the second quarter of Year 3 but had to be delayed due to the political unrest that started in October 2006. They have been rescheduled for the second quarter of Year 4. MHPP has made significant strides in facilitating and increasing the chances of sustainability by introducing a self-assessment approach which required simplifying the process and making it more accessible by the municipal authorities and ward committee members.

There is no question that every member of the MHPP has totally **internalized project objectives** and is committed to its unique approach. It would be impossible for a group

of 28 individuals to work as hard and effectively as they do and achieve the results that have been noted without understanding and accepting community empowerment and mobilization as core values.

All levels of the project are intimately familiar with **MHPP monitoring and evaluation plans** because they were involved in drafting the project as well as annual plans. The baseline and follow-up KPCs, the HFAs, the capacity assessments at the municipal and ward levels were part of these plans. One of the unique features of the MHPP is the focus and tracking of process and the resulting results orientation on both health as well as capacity strengthening indicators. The monthly and quarterly activity monitoring in each municipality pays close attention to what has been achieved and existing barriers and challenges. With the involvement of municipal- and ward-level participants in the monthly, quarterly and annual planning exercises and with everything done by consensus, there is a high level of ownership which benefits the project in the short term and is expected to improve the chances for sustainability in the long term.

**MHPP uses the monitoring data** to collect to manage the project at several different levels. For example, it has taken the findings of the Mid-Term KPC in the two Learning Center municipalities and tried to figure out how to re-energize the project there. It has already trained the MHD staff as trainers so that they can now train the replacement CHVs and provide them with refresher training more frequently. In addition, MHPP will be helping the LC leaders on budgeting so that they appreciate the minimal costs that are involved in such special events as Breastfeeding Week and World Health Day. It is expected that these efforts will enable and encourage the LC municipalities to take a more active role in supporting health activities in their urban centers.

Concern Worldwide Bangladesh has played and continues to play a leading role in the development and implementation of the **C-IMCI** in Bangladesh. It helped plan the national strategy and show the way for others. They have demonstrated how PPs/RMPs, and soon homeopaths, are important resources in addressing common childhood illnesses and demonstrating how they can be integrated into the health system. The MOH has adopted the strategy and will be using Concern Worldwide Bangladesh's curriculum for the training of these healers throughout the country. This practical approach is based on data that shows that the majority of mothers go to these private practitioners first when their children become ill with diarrhea or ARI. Once again, Concern Worldwide is taking advantage of resources that already exist within the community (like the CBAs, Imams, teachers) and links them to the health system so that they can play a positive role in improving the health status of the population.

*Challenges and Constraints* – While MHPP's planning process has been participatory and comprehensive, it was a bit optimistic when it came to WHC formation. This vital process took considerably longer than originally thought. To MHPP's credit, they wanted to ensure that the local committees were formed properly and were strong and capable of leading the health effort. They did not rush the process for the sake of staying on schedule. The review team feels that the MHPP will be stronger and more sustainable as a result of the greater care devoted to WHC formation. It should also be repeated that

the political environment has delayed project implementation. It can still cause problems, especially when elections are called, but with the WHCs now formed and functioning, activities can now continue at the local level.

## **B. Staff Training**

Concern Worldwide Bangladesh has distinguished itself as a builder of capacity at the municipal and ward levels, but it has also done well by its own staff. Under MHPP, they have provided **training in a number of areas**, including courses in negotiation, conflict resolution and decision making, emergency preparedness, report writing, presentation skills and problem solving. In addition, there are quarterly meetings of the MHPP staff which include skill building sessions. The staff is asked prior to the meeting about what topic they would like covered. The staff interviewed thought they were better managers after having received the training.

Several staff members mentioned **additional areas** that they would like to be trained in. One of the areas identified was sustainability which receives so much attention but there has been no training on the topic. Also mention was institutional or organizational development. To date the only training the MHPP staff has received on this aspect is on-the-job learning. Staff members thought formal training in this area would improve their performance.

Staff feel that they can discuss specific trainings that they would like to receive and can approach and discuss with the **Human Resources Department** of Concern Worldwide Bangladesh. The HR staff will determine if additional staff wants similar training. If there is sufficient demand, a group training will be arranged; if not, they will look for training courses in which the person can be enrolled. One MHPP staffer requested and received training (a five-day course) in research methodology. For group training, the Continuing Education Center (CEC) in Dhaka is often contracted to provide the training and the quality/effectiveness of their capacity building is said to be good.

Career development and individual training needs to increase capacities and improve performance are a part of the annual **Performance Review** process. This gives the employee an opportunity to discuss their personal desires and needs. At the same time, the supervisor is able to identify special needs to growth or training that can improve the staff member's performance.

In the MHPP, the staff have had to adjust from providing all the training to all project participants at the municipal and ward levels, to being the **trainer of trainers**. This takes a different set of skills and they have to become experts in such things as adult learning and skill building of those that will be doing the training. This transition has gone smoothly and, in the process, training capabilities have been built at the community level which will serve the municipalities well in the future.

MHPP staff have also attended a number of **conferences and professional meetings** to present papers on the project and its accomplishments. These are opportunities for staff members to learn and share experiences with experts from other countries and projects. They have also attended professional meetings in Dhaka at places like ICDDR, B. But, importantly, these are also opportunities for MHPP to disseminate results of what they have achieved and explain the innovative approach they have used. MHPP has been represented at the International Conference on Tracking Progress in Child Survival (London, 2005), APHA and, later this year, at the International Conference of Urban Health.

**Exchange visits** are important to Concern Worldwide's program in Bangladesh. Not only do they use effectively within and between municipalities, but they also exchange visits with programs in other countries. MHPP staff have the opportunity to visit other countries (e.g., Nepal in early 2007) and other Concern visit MHPP in Bangladesh (e.g., the Francophone – Rwanda, Haiti, and Burundi - health exchange in May 2006 to observe the C-IMCI and community mobilization aspect in MHPP).

Concern Worldwide US continues to be very active in its participation and contribution to **CORE and CSTS+**. Its Health Adviser has been involved in a number of working groups, specifically IMCI, Social Behavior Change, HIV/AIDS and Nutrition and contributed to the development of the Lives Saved Calculator. She served on CORE's Board of Directors until 2006. Moreover, the Health Adviser is called upon regularly to present at CORE and CSTS+ events, including the Mini-University. In a few short years, Concern Worldwide US has gone from a newcomers in Child Survival programming to a respected, valued leader in the community.

*Challenges and Constraints* – One area that Concern Worldwide Bangladesh might consider is a **training benefit** for its employees. This may be more of a Human Resource issue but it is covered here under staff training. Employees that enroll in a fulltime graduate program have to resign in order to pursue the degree. They are told that they will be given preference if they want to return to Concern Worldwide Bangladesh, but no leave of absence is given for long-term study. For those who undertake study while continuing to work at Concern are given up to 10 days of leave each year to study for exams. There is no financial support for those enrolled in work-related study. However, Concern Worldwide Bangladesh does support short course that are relevant to an employee's job (e.g., 3-month course on nutrition in Australia).

**Recommendation #24** – Concern Worldwide Bangladesh might consider support of long-term training that is directly related to a person's job and will improve that person's and project's effectiveness.

The one area that was found to be weak was **Quality of Care**. This was mentioned in the appropriate sub-section above. But it is included here because several people in MHPP should be trained in Quality of Care and be responsible for increasing the consciousness and capacity of the project in this important area. Although MHPP has planned

workshop on Quality Assurance for later this year, that may not be sufficient. It will be a challenge since, as noted, there is little consciousness or demand for quality at present.

**Recommendation #25** – MHPP should train two or three staff persons in QoC and make them responsible for building staff and counterpart awareness and capacities in this aspect.

### **C. Supervision of Program Staff**

The MHPP staff expressed satisfaction with the supervision they receive from Concern Worldwide US. They receive advice and technical assistance and provided quality consultants when required to strengthen the program. Supervision from Concern Worldwide Bangladesh office in Dhaka has been **intensive** since both the Technical Manager Research and the Head of Health and Nutrition are based there. The review team thought that it might be worth considering having the Project manager based in Concern Worldwide's Rangpur office. Getting back and forth from Dhaka and the project area in the north is more difficult now that it was in the CSP or during most of the first half of MHPP. The national airline has recently terminated its flights to the region. While there used to be two choices (either Rajshahi or Saidpur), now there are no flights. Thus, instead of taking less than two hours to reach the project site from Dhaka, it now takes almost a full day to go from Dhaka to Rangpur. And during the last two years of the project, the Project Manager will be needed on a regular basis on site to ensure that the myriad of things that have to get done are done and done well. The important work in Dhaka, especially the developing of a feeling of ownership and institutionalization in the MOLGRD&C, can and should be done by the Promotion and Liaison Officer that has been recommended earlier to establish a relationship with counterparts at the central level.

In general, supervision at every level is **supportive**. It is part of the corporate culture at Concern Worldwide. Each team identifies support they will need in the next month and the supervisor allocates time for each employee. At the end of the month, managers review what support was given/received and what will be required in the next month. In addition to the MHPP staff, supervisors also provide support and supportive supervision to the MHD staff, cabinet and WHC members, including the leaders.

One thing that stands out about the MHPP and Concern Worldwide staff is that they function as a team. **Teamwork** is highly valued by the organization. There is no evidence of internal friction and everyone seems to be working for the common objectives without undue thought or concern for their individual advancement or recognition. MHPP goals come before personal considerations. This spirit is evident to the partners and seems to have rubbed off on the CHVs and CBAs to be sure. It may have even influenced some WHC and municipal officials and authorities but this will only be evident with the passage of time.

### **D. Human Resources and Staff Management**

Concern Worldwide Bangladesh has a **personnel manual** that spells out all staff benefits and personnel policy for the agency. All field positions have specific job descriptions. They are used as part of the annual Performance Review process – it is against the job that the staff member is supposed to do that the employee is measured. The process is well developed and is similar to the review process that many groups use. The employee does a self assessment, reviewing what they have done during the past year. Beyond this, the staffer identifies what s/he would like to do in the coming year to develop themselves. This could take the form of special training or different type of work within the project. This exercise should make them a better professional thereby helping the project achieve its objective and goal more expeditiously.

Without exception, the MHPP **staff works long and hard**, often late into the night and on weekends as well as holidays, indicating a high degree of loyalty, dedication and commitment. It is not uncommon to hear staff say that to work for Concern Worldwide Bangladesh means “you must be ready to work after hours”. This is not surprising since the ratio of staff members to population went from one to approximately 8,000 in the CSP to one to over 35,000 in the greatly expanded MHPP. The fact that the MHPP partners work six days a week and WHC meetings are conducted during the evenings do not help. These long hours can take their toll. Some of the project staff note the lack of balance in their lives. They work hard and don’t have enough time to pursue personal goals. It can even have an effect on family lives and the social lives of the younger staff.

One way to ensure that the staff members have a better balance in the lives is to encourage them to take the **vacation days** they earn. Now staff members say they don’t have time to take vacation days. The possibility of carrying unused leave forward was raised in the CSP evaluation. While staff are now able to carry forward and use in the first two months of the next year, this is not sufficient and vacation days end up being surrendered. Staff are also able to earn compensation (i.e., “comp”) days, but, once again, they do not have an opportunity to use them. There is always too much to be done. In an effort to improve staff performance and guard against “burn out”, Concern Worldwide Bangladesh is encouraged to do more to ensure staff takes the vacation days they are due.

This intensity and demand for personal sacrifice along with the difficult nature of the work may be reasons explaining some **staff turnover**. The review team was unable to interview any of the staff that had left MHPP, so their reasons for moving on are not known. But it is suggested that other jobs, paying as well or better, are appealing especially if they are located in a major city, like Dhaka. Several Project Managers in Rangpur as well as managers for two other municipalities plus two Field Trainers (Gaibandha & Bogra) had left their posts to pursue other options. It was not possible for the review team to interview any past staff but it would be worthwhile for the human resource people at Concern Worldwide Bangladesh to meet with departing staff to determine reasons for leaving the project. This would provide valuable feedback that could result in changes that might decrease staff resignations that would reduce project disruption (requiring new staff recruitment, training, learning) thereby improving implementation.

Staff told the review team that pay at Concern Worldwide Bangladesh was somewhat below that paid for other large international NGOs in Bangladesh. It was estimated that salaries at Concern may be 10% below other similar groups. Every employee receives a Cost of Living Adjustment (COLA) once a year so that his/her salary keeps up with inflation. In addition to the COLA, each employee is given a “**one-point**” (or **step**) **increment**. There is no variation – you receive the same one point increase regardless of your performance, good, bad or indifferent. This does not provide any incentive for staff members who either perform below the norm or far exceeds it. For this reason, it is suggested that Concern Worldwide consider introducing a system which gives one step increase for good performance, no increment (other than COLA) for below average performance and two steps for superior performance. Good performance should be rewarded and those performing poorly should be held accountable. There should be a roughly similar number receiving extra increments as receiving none at all – the distribution should resemble a bell-shaped curve.

The problem, according to Concern managers who have been in the organization for many years, is that it was tried before and providing variable “scores” led to a lot of not always helpful **competition** on one hand and **dissatisfaction** on the other. But the way it is at present means that there is very little or no incentive for staffers to work a little harder. Other organizations have such a variable annual increment system and have made it work.

**Recommendation #26:** Concern Worldwide Bangladesh should conduct a nationwide survey to determine what a fair and accurate pay scale might look like. Efforts should be made to keep Concern salaries in line with other INGOs. In addition, it should encourage staff to take annual leave days that they earn.

**Recommendation #27:** Concern Worldwide Bangladesh should consider giving annual performance-based salary increments.

The current heavy workloads suggest that this is not the time to reduce staffing levels. According to the DIP, a number of positions are to be done away at the beginning of Year 4. The rationale for such a reduction is sound, but the reality makes it inadvisable at this time. Because MHPP is behind schedule for reasons explained above, there is considerable work that remains to be done and a number of these staffers are crucial. The five staff members in question as two field trainers (in the larger municipalities), one training officer, one M&E person and one operations manager. The review team thought that it made sense to **retain** these five **staff** members for an additional year, and reducing staff after MHPP is fully operational (i.e., all teachers, PPs and religious leaders have been trained) and HMIS has been introduced and is functioning satisfactorily. In Year 5, the NGOs will phased in and assume more of an operational role and these particular staff members will have provided already made their maximum contribution and the project will be better able to do without them.

**Recommendation #28:** MHPP should retain the five staff members that were slated to leave the project at the end of Year 3 and DIP and budget should be revised accordingly.

The Program Manager currently is residing in Dhaka. Although he visits the MHPP Project area frequently, it might be worth considering deputizing one of the Operations Managers or Technical Coordinators to serve as **Deputy Manager** with the authority that would allow him/her manage the project effectively during its last two years. This would permit the Program Manager to focus a little more attention on advocacy and working with the Promotion & Liaison Officer in Dhaka.

## **E. Financial Management**

Concern Worldwide US's and Bangladesh's **financial management** of project expenses and budget were found to be in order. Field personnel said that they received timely budget analysis. Monthly financial reports keep project management aware of current project finances and alert them of potential problems. This was evident in that project management was totally aware of the projects financial situation. They are aware of the overspending Year 3 of the MHPP. In fact they have already asked Concern Worldwide US to make up almost \$35,000 shortfall in the current fiscal year.

MHPP was slightly under-spent (94% of the combined USAID/Concern budget) in Year 1. In Year 2, USAID was **over spent** by 9% while there was a considerable overrun in the Concern Worldwide budget (199%). Concern Worldwide US agreed to make up the difference from unrestricted donor funds. The situation in the current fiscal year (through June) is very similar to Year 2 in that the USAID budget was over-spent by 114% and Concern's budget by 200%.

It is expected that the **Year 4** (10/2007-9/2008) budget will not be sufficient due to the retention of the five staff members that were programmed to leave the project but will now be kept on to complete capacity building and program development. It is estimated that this will cost Concern approximately US\$20,000. In addition, the new person in Dhaka who will be responsible for promotion and liaison will have to be added to the Year 4 budget. This will be an additional US\$15,000 - 20,000.

The financial short fall has been the result of several **different factors**, including inflation (6-7%/year) as well as significant increases in the price of both diesel (150%) and petrol (200%). The project is widespread with the six municipalities being anywhere from almost an hour up to two plus hours away from Rangpur where MHPP offices are located. As a result, transportation is a major expense. Exchange rates favored the project with the value of the dollar increasing some 30% from the start of the project, but it was not sufficient to compensate for higher costs in other areas. MHPP, and Concern Worldwide Bangladesh in general, appear to be run in a very cost-conscious and efficient manner.

MHPP received US\$300,000 in the form of **field support** from the USAID mission in Dhaka. It is quite unusual for a USAID mission to allocate their own resources. It is a

positive indicator of mission interest in what Concern Worldwide is doing. It is hoped that they can play a supportive role in institutionalizing at the national level the urban health strategy that has been found to be effective.

In terms of **cost per beneficiary**, the MHPP is very reasonable. It works out to \$1.37 per year for each of the targeted population (all women of reproductive age and children under the age of five) in the seven municipalities. This is a very conservative figure since it does not include the target population in the two Learning Center municipalities. The cost is low primarily because MHPP is a capacity building and not a service delivery project. That is not only positive in the short term but good in the long term as well since the recurrent costs are minimal, thus improving the chances for sustaining the effort.

## **F. Logistics**

Because the project does not provide any hardware to the municipalities, there is very **little procurement** in the MHPP, hence only a minimal amount of logistics involved. Staff members said that any logistic issues that arise are handled effectively and efficiently. One example is training materials which have to be printed and delivered to the involved municipalities. Project coordination and connectivity will be greatly improved shortly as all seven offices is linked via the Internet. Although service in most of the project municipalities is very slow (only Bogra has broadband), the ability to share data and documents will be a welcomed addition.

In general, logistics was not found to be a problem. Things were done on time. This is because MHPP established a system whereby procurement needs were discussed at the monthly project meeting, orders placed and deliveries made according to project requirements. All procurement was done centrally in Dhaka.

## **G. Information System**

In CSP, Concern Worldwide received technical assistance from ICDDR, B in HMIS. They were a partner who was tasked with **designing a system** that would allow the communities to monitor key indicators relating to their health status. ICDDR, B was used to working with public authorities and, as a result, they developed a system that was cumbersome and depended on the MHD to be implemented. MHPP realized that the MHDs were very weak and short-staffed and it would be problematic if they were expected to collect and process data for all the wards in their respective municipalities. Instead, MHPP thought it was more practical and effective to rely on the communities themselves and the energetic, bright young CHVs to establish and maintain the HMIS. With CHVs being responsible for approximately 50 households, it is not difficult for them to be familiar with a limited set of indicators relating to maternal, infant, child health and nutrition. The system they have developed has a much better chance of being effective and integrated into the community health structure that has been established. WHC highly value the data they derive from the HMIS and have indicated a willingness and capacity to use the information they collect and process for decision making purposes.

After testing the HMIS in 14 wards, (two in each municipality) and finding it both feasible and effective, MHPP has made the decision to **introduce it in all the wards** as soon as practical. Training the teachers who sit on the WHCs as in the HMIS so that they can train the existing CHVs and then monitor and supervise its operation, is most appropriate. As Recommendation #16 suggests, MHPP should move forward and introduce the HMIS throughout the project and should waste no time in doing so.

At a higher level, MHPP has made strides in several other M&E areas. The capacity assessment tools for the WHCs and the MESPCCs have been utilized and baseline data collected. As a new feature, these two entities have been trained to **self-assessments** using the same technique. The process and indicators have been simplified without losing effectiveness which makes it possible for the community members to carry out this valuable exercise on their own, facilitated only by a member of the MHD (in the case of WHCs) and the project manager for the MESPCCs. This greatly increases the ownership, the understanding of the most vital aspects of what makes a local body function effectively while at the same increasing the chances that the process will be utilized long after MHPP comes to an end. In addition, by involving the MHD and other partners in the baseline as well as mid-term KPCs, MHPP has developed local capacities to use LQAS techniques which could also pay dividends in the future.

Recommendation #6 relates to the introduction of **referral slips** so that the work of the CBAs, CHVs and PPs could be tracked and monitored. This will add another dimension to the MHPP and increase both its effectiveness by establishing a closer link with the health infrastructure, both at the MCWC as well as at the district hospital.

## **H. Technical and Administrative Support**

MHPP has strong and innovative **leadership** at all levels. At Concern Worldwide US, the Health Adviser has continued to be a source of important support for the MHPP. More recently a Program Officer (Health) has joined the effort and is taking a greater role. At the Dhaka level, several Concern Worldwide Bangladesh officers provide direction, managing and overseeing implementation on a daily basis. At the high level, the Assistant Country Director who was intimately involved in the development of the urban health model, continues to provide the vision and keep the bigger picture in view. The head of health and Nutrition for Concern Worldwide Bangladesh has devoted significant time and energy to MHPP, contributing his thoughts and technical expertise to streamlining the model and making it more sustainable so that it could be scaled up and cover a significantly greater population. The Program Manager who assumed responsibility for MHPP at its inception has been tireless in his management of the project, ensuring that its implementation moves forward according to the DIP without compromising the basic community-orientation and ensuring local ownership. The MHPP team has been well served by this hierarchy and the results achieved to date are a testament to their skills.

Concern Worldwide has taken advantage of their close relationship with CORE and CSTS+ to keep abreast of the latest technical guidelines and innovations. The **technical assistance** used in MHPP has been helpful to the project. Concern Worldwide US provided support to facilitate the DIP and refine and improve the capacity measurement process. CSTS introduced the MAMAN framework and field-tested the Rapid Child Health Services Provision tool at the MHPP sites. Consultants were also made available to develop and then refine guidelines for the PPs **for the national IMCI working group**. BASICS III was helpful in advising on the monitoring and evaluation plan for the PP component. Concern Worldwide Bangladesh and MHPP continue to lead the effort to institutionalize C-IMCI and striving to have it accepted as policy in Bangladesh.

## **V. Conclusions, Lessons learned and Key Recommendations**

### **A. Conclusion**

The Mid-Term Review team found that the MHPP had made **significant progress** on two fronts. First, the project had **built the structure and the capacity** at the municipal and ward levels, despite a difficult political environment. Although a little behind schedule in the training of some cadre of community change agents (e.g., teachers, PPs), the WHCs and community members (including CHVs, CBAs, Imams) are actively engaged in the health program. The best way of demonstrating their involvement and understanding of the health program is the second indicator of effectiveness, **health outcomes**. Despite devoting a considerable amount of their energies during the first half of the project to process/capacity-building activities, Concern Worldwide and the MHPP partners achieved some significant health improvements. Table 2 shows that most of the indicators of maternal and newborn, child health and nutrition/micronutrients programming improved, some considerably, over the baseline KPC. This is encouraging and demonstrates that the results achieved in the CSP and reported in the final evaluation were not exceptional or unique. Concern Worldwide Bangladesh and US have proven that the urban health model they developed in cooperation with the selected municipalities of Rajshahi Division can be expanded dramatically (six fold) and still produce impressive results. So while people may have been skeptical of the model and the results after the CSP, they cannot be any longer after seeing the accomplishments of the MHPP.

This MTR identified a number of things that needed attention by the MHPP staff during the last half of the project. Many of these were already identified by the MHPP managers. One problem was the drop in some of the health outcome indicators in the two CSP municipalities, the Learning Center. Not only did they provide a brilliant opportunity for the municipal authorities an opportunity to see and learn about the urban health model, but it also provided the Concern Worldwide managers a chance to experience what happens after the NGO leaves and the municipalities have to assume responsibilities for project activities. The result was a gradual loss of energy, almost like a battery running down. The program needs to be recharged periodically if it is to continue to provide the results seen at the conclusion of the CSP. To do this several things are important – e.g., training the MHDs as trainers to train new CHVs and refresh

the existing corps, helping the municipalities to budget for such things as special activities (festivities focused on health like Breastfeeding Week and World Health Day). In addition, the role of the local NGO as the local motivator or promoter, assuming some of the role of Concern Worldwide, was verified as being very important. These achievements and lessons will be very valuable as Concern Worldwide now focuses more attention on advocacy and promoting the expansion throughout Bangladesh of the urban health model by other partners.

## **B. Lessons Learned**

Besides the lessons on sustainability learned through the Learning Center municipalities of Saidpur and Parbatipur, Concern Worldwide Bangladesh and US and all the MHPP partners and stakeholders, at both the municipal and ward levels, take away a number of practical and programmatic lessons that can/will be applied in the second half of the MHPP. Moreover, any organization implementing the approach in other municipalities would be well advised to heed these same lessons.

1) **Scaling-Up Requires Streamlining**: The CSP model was successful in the two relatively small municipalities (total population approximately 150,000). But when MHPP expanded to cover a population of over 850,000, significant changes were required to allow Concern Worldwide Bangladesh to reach the vastly enlarged target group. A number of modifications to the model/approach were introduced in the MHPP – including training the MHD staff as trainers (to train CHVs and WHCs), only orienting the MESPPC members rather than training them for 13 days, training of Imams by Imams, teachers by teachers, and self-assessments to monitor capacity at ward and municipal levels. The role of Concern Worldwide went from facilitation and implementation to purely facilitation. In addition, a system was developed and introduced to identify and ensure inclusion of LAG. All these changes improved the efficiency of the scaled-up version of the urban health program and made it possible for the MHPP to cover a much larger target population with a limited staff while not compromising health outcomes.

2) **Seeing Facilitates Understanding**: Seeing may be believing, but in the case of Concern Worldwide's urban community-based health program seeing allowed municipal authorities in the seven new urban centers to appreciate what was involved and what it would look like and how it would function in their municipalities once the structure and capacities had been built. It is impossible to prove, but based on what the review team was told, the MHPP would not have made as much progress in its first several years had it not been for the Learning Center. Officials who were skeptical before visiting Saidpur/Parbatipur returned to their municipalities as converts, believers and committed supporters. This is particularly important in a program that primarily involves capacity building and improvement in processes like coordination, organization, communication and mobilization. This is opposed to more technical interventions that center around specific activities that might include things like growth monitoring, immunization or contraceptive distribution. The “softer” the intervention, the greater the need to demonstrate what it is and what it means for those who might be adopting the approach.

The more ambiguous or amorphous the intervention or program, the more valuable it is to have a Learning Center where prospective adopters can observe and discuss the intervention with those that have already implemented and benefited from the approach.

**3) Strong Leadership Is Essential:** This is true at all levels. It has been demonstrated in the MHPP at the municipal and ward levels during the first half of the project. When municipal chairmen or ward commissioners are not available, there is a vacuum. At times member secretaries step in to fill the void but, as recommended, it is important that alternative leaders be identified and given the authority to assume responsibility as long as the elected leader is indisposed. The review team also noted that national leadership is vital if the urban health model developed and tested by Concern Worldwide is to be adopted on a larger scale. The responsibility for introduction now passes to the MOLGRDC under which municipal health falls. If the remaining 299 municipalities in Bangladesh are to benefit from the successes achieved in the nine municipalities of Rajshahi Division, the Ministry has to take ownership and initiate efforts to interest donors and others to roll out the community-based capacity-building approach. The MOLGRDC must decide who will oversee urban health and expand the approach. Concern Worldwide should become the technical advisers for urban health rather than the initiators/facilitators. Making this happen will be the most important part of the job for the new Dhaka-based Promotion/Liaison Officer which the review team has recommended.

**4) Data Empowers:** The MTR team learned that the WHCs and the CHVs highly valued feedback on their work in the health sector. The wards where the MHPP HMIS was introduced seemed to be more engaged and committed than those without. The HMIS made it very clear what they were working for as well as gave them feedback on how they were doing. Despite the time and effort required to put the HMIS in place, none of the CHVs or WHC members objected. The information provided was seen as being worth their investment. Once the HMIS has been introduced and is working in all 75 MHPP wards, there will be an opportunity to use the data in more creative ways. The review team thought that the selection of two or three of the most important indicators (e.g., vitamin A coverage, ANC coverage, delivery in health facilities), and posting them in the WHC for all to see regularly could help motivate the WHC. The municipal health authorities could compile these every month and circulate to other wards in their respective municipalities. This will initiate friendly competition and stimulate more community support for the work of the CHVs and WHCs. .

**5) Community Involvement Increases Accountability:** The MTR team was impressed at the increased demand for such services as ANC at the MCWCs. With more women coming for care, the local facilities have to improve the quantity as well as quality of the services provided. The community is now making additional demands on the centers. Community involvement also increases the role and importance of the MHD staff. Heretofore, the MHDs had limited responsibilities and were often not very active. With the MHPP, the situation changes dramatically. Each MHD staff member is assigned to one or more WHCs and assists them in their operations. As mentioned, there is limited accountability from above for the MHD, especially from the MOLGRDC. But this

accountability from below, from the wards and community, is effective in energizing and motivating the MHD staff to carry out their support role with more attention and commitment.

**6) Political Leaders See Benefit in Community-Based Health Intervention:** Discussions with the ward commissioners and municipal chairmen during the MTR made it clear that they are beginning to appreciate the political benefit that can be derived from supporting the MHPP activities in their respective jurisdictions. It provides a way for them to demonstrate their commitment to and caring for the well-being of the community members. Being intimately involved in improving the health status of the municipality improves their image. It should have an effect on their political popularity. This, of course, is hard to determine until a local election takes place. Elections are scheduled to be held in the municipalities in March or April of 2009 which will give the project an opportunity to see if those political leaders (i.e., commissioners and chairmen) who have been especially supportive of and involved in the health program are reelected versus those less committed who are not. The positive political impact of the MHPP should be followed-up and noted in the final evaluation of the program.

**7) Sustainability Requires Planning:** Sustainability is not something that can be planned for and make happen in the last month or even year of the project. Rather, sustainability plans must be considered and integrated into program design and be part of implementation from the beginning. The capacity of a municipality to manage and run their own affairs is crucial to being able to sustain the effort after MHPP comes to an end. MHPP has done a good job at not just building capacity at the ward and municipal levels but in addition, a mechanism has been put in place so that the process can be measured and monitored. Concern Worldwide Bangladesh and US are aware of the danger of the municipalities becoming “process dependent” on them. For this reason, MHPP is working actively with the NSDP NGOs in the respective NGOs to ensure that they are aware of how the urban health program works and can provide the support (i.e., “pushing”) required once MHPP comes to an end. MHPP plans to turn over management and support of the MHPP in the last year of the project to the NSDP NGO to be sure that they know what to do and are able to do it effectively and efficiently.

**8) Least Advantaged Group:** The final evaluation of the CSP found evidence that the project had not reached many members of the LAG in Saidpur and Parbatipur. This was a concern since they require the services most and making significant health impact depends on ensuring that the least advantaged population, who has the worst health status and bring the performance in many of the key project indicators down, are reach and actively participate/benefit. In the MHPP, Concern Worldwide has demonstrated that it is possible to reach this vulnerable group and actively involve them in the program. The project did it by developing a system whereby each very poor household in a CHV’s zone (approximately 50 households) is identified and listed. CHVs, with the support of the WHC, place special attention on the LAG members in their area – visiting them more often and making sure they receive the life-saving services such as childhood immunization, vitamin A and family planning. The systematic approach taken by the

MHPP has proven effective and may be partially responsible for the positive outcomes shown in Table 2.

### C. Key Recommendations

Based on the findings of the MTR, approximately 30 recommendations have been included in the Results and Findings Chapter. However, the review team thinks that ten key recommendations are particularly important and are highlighted here. The first five apply to Dhaka-centered advocacy and the last five are more associated with the MHPP in the seven municipalities in northern Bangladesh.

1) ***MHPP Officer in Dhaka*** – After what will be a decade devoted to urban community-based health programming, including the scaling up to cover significant population and achieving positive results, Concern Worldwide has nothing more to prove. Now is the time for the MOLGRDC to assume ownership and responsibility for rolling the model out in the 299 remaining municipalities. During the remainder of the MHPP, its most important task is **institutionalizing** urban health in the MOLGRDC. This is no small task. It has been attempted by other donors, including USAID, several times since the first half of the 1990s, but it still has not been achieved. It is recommended that MHPP hire a Promotion/Liaison Officer to be based in Dhaka to devote full time to working with the ministry as well as donors to institutionalize what Concern Worldwide has developed and found to be effective.

2) ***UPHCP-2 and Bogra*** – One of the principal donors in urban health is the ADB. Their UPHCP-2 is now being implemented. A major component is the building and staffing of health centers in the five municipalities where they are working. One of these is Bogra, which is also one of the MHPP municipalities. This provides an excellent opportunity to liaise with UPHCP-2, learn more about its approach and see how it can benefit from the MHPP community-based model. The MTR team thought that there is complementarity between the two approaches with a great potential for synergy. It is recommended that MHPP make a concerted effort to link and work with UPHCP-2 in Bogra to see how the Concern Worldwide and ADB approaches can most effectively work together. If possible, integration of the MHPP approach into UPHCP-2's other municipalities might be considered.

3) ***Inter-Ministerial Coordinating Committee*** – The IMCC is a mandated body. It was formed in the mid-1990s and functioned briefly. But when donor support came to an end, it became inactive. It was never institutionalized. The role of the IMCC is vital if urban health is to become a reality and get the support it requires. It is this entity that brings the ministries (e.g., Health and Family Welfare, Education), the donors, NGOs and other interested parties (e.g., Association of Municipal Chairmen) together. Advocating for the reformation, revitalization and support of the IMCC at the MOLGRDC would be one of the important responsibilities of the MHPP Promotion/Liaison Officer. It is recommended that MHPP work with its urban health partners to make the IMCC functional.

**4) Start-Up and Operating Costs** – If the MHPP model is to be adopted by the GOB and/or donors and expanded throughout the country, people will want to know how much it will cost to establish the structure and build the capacity at the municipal and ward levels. In addition, it is important for all to understand what the recurrent or operating costs are once the urban health system is up and running. MHPP has started to calculate these costs and the results, once available, should be disseminated widely. The costs, both start-up and recurrent, are not exorbitant and all should know that they are reasonable and well within the means of donors and government. Moreover, the costs are particularly inexpensive when outcomes are taken into account. It is recommended that MHPP complete the costing exercise and draft a short paper that provides the information and then hold a dissemination workshop on the cost of urban health programming so that the results can be shared.

**5) Change to DIP on Staffing** – According to the DIP, six important members of the MHPP team (Field Trainers, trainer and M&E) are scheduled to leave the project at the end of Year 3. Because the implementation of MHPP was delayed (for reasonable cause), these staffers will be required for another year. Of greatest need is the completion of the training (CHVs, PPs, religious leaders, teachers). In addition, the HMIS will be introduced in all wards. MHPP staffing is very thin to start with and all project personnel are already working more than full time. The review team recommends that those team members due for termination the end of September be retained for an additional year or at least until the NSDP or local NGOs assume greater responsibility for the operation of the MHPP activities in the project municipalities.

**6) Full Implementation of the HMIS** – The development and the piloting of the HMIS has been highly successful. All those that have been involved in implementing it in the 14 wards of the project municipalities have expressed their support for the system. As mentioned in the Lessons Learned sub-section above, the data provided by the HMIS gives the community the information they need to make decisions and improve their health status. The MTR team strongly endorses the HMIS design and recommends that the MHPP proceed as rapidly as possible to introduce it in the remaining 61 wards of the seven municipalities. It is further recommended that the teachers who are members of the WHCs should be trained as trainers in HMIS so that they can train the existing CHVs and serve as technical HMIS support as required. This should improve the sustainability of the HMIS.

**7) Develop Phase-Over Package** – The transition from MHPP to municipality control of its health activities consists of several important steps that have been mentioned: e.g., NSDP/NGO involvement as the process managers plus support and reinforcement and the costing calculations. In addition, the MTR team recommends that the MHPP put together a package (almost a tool kit) that includes everything that a municipality, implementer or donor, requires to establish and implement the urban community-based health approach as structured by the MHPP. It would include a step-by-step guidelines, job descriptions for the managers, curricula for the various volunteers (CHVs, CBAs, religious leaders, teachers, PPs), drafts memorandum of understanding, details on the

capacity assessment tools, etc., etc. This will help ensure that the approach is maintained and is not distorted or reinvented.

**8) Phase-In NGO in Last Year** – The phase-over process should begin in Year 4 of MHPP with the NGO having primary responsibility for operations in their respective municipalities in Year 5. This idea has been mentioned in the CSP final evaluation as well as above in the MTR report. This is important since the Learning Center demonstrated that there continues to be a need for an outside source to prod/motivate (i.e., “push”) the municipalities after Concern Worldwide phases out. This entity keeps the energy flowing and ensures activities continue. The group selected to do this must benefit for the arrangement to be motivated to support the health activities. The review team recommends that MHPP continue to work with the NSDP NGOs or, where they don’t exist or are not effective, a specially selected NGO working in the municipality, orient them on the MHPP approach and ensure that they appreciate how it can assist them in achieving their own objectives.

**9) Improve Referral System** – When all the PPs are trained and the district hospital staff oriented on the MHPP and the WHC/CHV activities, a referral system should be established. There is already a close working relationship between the CBAs and MCWCs, and CBAs are already referring patients to the MCWCs for ANC and delivery. However, at this point, they do not use and do not have referral slips. A close relationship should also be established between the CHVs and the PPs with the district hospital providers. The MTR team recommends that all PPs and CBAs be given referral books – possibly printed in different colors so that who is referring can be distinguished at a glance. In addition, the CHVs and WHCs, health promoters, should have a referral linkage with the district hospitals.

**10) Improve Quality of Care** – More attention should be given to improving the QoC in the health facilities utilized by the urban populations. This is particularly true of the MCWCs which are the principal referral sites for pregnant women. Of major concern is the limited staffing, a problem that the IMCC could address once it is functional. In addition, it could also attempt to solve the problem of the lack of Medical Officers in the municipalities. It is recommended that MCWC providers be aware of standards and protocols and that at least one provider at the facility be trained in IMCI so that quality child health services are available.

Overall, the MHPP has made significant strides in demonstrating how the health status of the urban population of Bangladesh can be improved. It is now up to Concern Worldwide Bangladesh and the MOLGRDC to figure out how the approach can be institutionalized at the Dhaka level and rolled out so that all the municipalities of the country benefit from the learning that has taken place in the MHPP.

## VI. ACTION PLAN BY PVO

Following the midterm review, the MHPP staff and the municipal partners reviewed the recommendations, developed a team response and required action, and then updated the DIP workplan for years 4 and five which is in **Attachment X**.

Recommendation	Response
<b>Recommendation #1:</b> Concern Worldwide should consider adding a control municipality to the final evaluation so that achievements of the MHPP can be more attributable to the project interventions.	<ul style="list-style-type: none"> <li>○ We do not consider adding a control municipality on ethical ground.</li> <li>○ DHS was conducted in 2007 and preliminary results are expected in mid 2008. Change of % from 2004 BDHS and BDHS 2007 could be visualised</li> <li>○ We will explore whether other NGOs working in other municipality and we could use the data from them for comparison. Other possible options are comparing data with MICS</li> </ul>
<b>Recommendation #2:</b> The ANC patient load for the MCWCs in the seven municipalities should be studied and measures taken to assure that ANC services are available (using paramedical staff as required) to satisfy the demand.	<ul style="list-style-type: none"> <li>○ Program Manager MCH of DGFP has agreed to support increase of the ANC service day for one extra day. We will further advocate on it and an assessment will be carried out by using MCWC data on ANC services increase.</li> </ul>
<b>Recommendation #3:</b> PP/RMP and homeopath training should begin as soon as possible and be expedited so that these practitioners can become active supporters of improved child health practices	<ul style="list-style-type: none"> <li>○ We agreed with DGHS IMCI section for the TOT of PP and after the TOT the training will be launched in 1<sup>st</sup> quarter of year 4 of the project.</li> </ul>
<b>Recommendation #4:</b> Adopt an indicator for diarrhea treatment that refers to ORT and includes all three forms of rehydration.	<ul style="list-style-type: none"> <li>○ The M&amp;E team will review the indicator and make adjustment.</li> </ul>
<b>Recommendation #5:</b> The staff of the district hospital in each MHPP municipality should be familiarized with and oriented on the program's objective, the WHCs and their community volunteers.	<ul style="list-style-type: none"> <li>○ The 3 step QoC workshop is scheduled with District level Hospital and MCWC authority and we will discuss and orient the stake on MHPP and community engagement in health promotion.</li> </ul>
<b>Recommendation #6:</b> CHVs should be given books of referral slips so they can refer sick community members directly to the district hospital	<ul style="list-style-type: none"> <li>○ CHVs are the service promoter and referral might not be accepted by the hospital. Rather WHC could be given that mandate to refer the sick people which can be sustained as this is a recognised community structure.</li> </ul>
<b>Recommendation #7:</b> Efforts should be made to identify the root cause of the logistic supply problems that result in shortages of vitamin A and as solution found.	<ul style="list-style-type: none"> <li>○ This is in fact an agenda of MESPCC and we would further push it forward. The issue was from Parbatipur and we will work on it at the MESPCC level.</li> </ul>
<b>Recommendation #8:</b> The follow-up HICAP should be conducted as soon as possible to determine progress in the individual municipality's capacity and in what aspect(s) they require strengthening.	<ul style="list-style-type: none"> <li>○ Five remaining HICAP will be completed by 2<sup>nd</sup> quarter of year 4 of the project</li> </ul>
<b>Recommendation #9:</b> The MOLGRDC must give directions that each MESPCC should have an alternate leader, elected by the members of the MESPCC, and authorize this position.	<ul style="list-style-type: none"> <li>○ MESPCC is a coordinating forum of service providers at the municipal level. The respective Municipal Chairman plays the role of coordinator. The system is in build within municipality. A panel of commissioners act as acting chairman during absence of Chairman with authority and responsibility. We will</li> </ul>

	further advocate to continue the effort
<b>Recommendation #10:</b> Concern Worldwide should advocate and facilitate the formation of an Inter-Ministerial Coordinating Committee. They should orient its members and develop its initial action plans.	<ul style="list-style-type: none"> <li>○ We will advocate to activate the IMCC and will jointly develop the ToR for the committee as per the Ministry's guideline</li> </ul>
<b>Recommendation #11:</b> Concern Worldwide should add a National Promotion/Liaison Officer to its MHPP staff in Dhaka. His/her responsibility would be to build capacity and develop a support structure at the MOLGRDC to help sustain and expand the urban health model that is being implemented in the MHPP.	<ul style="list-style-type: none"> <li>○ Senior Advisor, CWB in consultation with Health Advisor, CW-US will make decision on the recommendation.</li> </ul>
<b>Recommendation #12:</b> Staffing deficiencies should be considered at the MOLGRDC and MOH levels to ensure that the urban health model is implemented properly/ effectively and that the demand generated through community involvement is satisfactorily responded to.	<ul style="list-style-type: none"> <li>○ We will further advocate on the issue at MESPCC and IMCC level</li> </ul>
<b>Recommendation #13:</b> Concern Worldwide should train several trainers in each municipality and they should train all Imams in their respective urban centers.	<ul style="list-style-type: none"> <li>○ We will have an assessment what and how far currently imams are doing and the agenda will be placed on WHC by Imams and we will work on it.</li> </ul>
<b>Recommendation #14:</b> Concern Worldwide should establish links with the UPHCP-2 and determine the most effective way for the two projects to work together to improve health status through community capacity building in the municipalities of Bangladesh.	<ul style="list-style-type: none"> <li>○ We will work on it both at Bogra and Dhaka level with UPHCP-2</li> </ul>
<b>Recommendation #15:</b> The training of new CHVs to replace ones that have dropped out should be done formally by the trained MHD staff as soon as possible and include formal details such as certificates and graduation ceremonies.	<ul style="list-style-type: none"> <li>○ This is an ongoing effort and we will work on it.</li> </ul>
<b>Recommendation #16:</b> MHPP should train the teachers sitting on the WHC as HMIS trainers in the near future so that they can train the CHVs in their WHCs and launch the new system before the end of the year.	<ul style="list-style-type: none"> <li>○ Teachers in WHC could be an additional resources and we will work on it</li> </ul>
<b>Recommendation #17:</b> MHPP together with its partners should develop a Phase-Over Package that will guide the transition from project support to self management	<ul style="list-style-type: none"> <li>○ We will develop Phase over package together with partners starting from the beginning of Year 4</li> </ul>
<b>Recommendation #18:</b> MHPP should turn over more facilitation responsibility to the partner NGO during the last year of the MHPP so that the latter can play a more responsible role in the implementation of the urban health program.	<ul style="list-style-type: none"> <li>○ We will work on it</li> </ul>
<b>Recommendation #19:</b> The DIP should be revised and the training staff at the municipal level should be kept at current levels.	<ul style="list-style-type: none"> <li>○ Senior Advisor, CWB in consultation with Health Advisor, CW-US will make decision on the recommendation.</li> </ul>
<b>Recommendation #20:</b> MCWC staff should be trained on IMCI to provide quality Child Health service to the community and efforts should be made to increase their knowledge about rational drug use.	<ul style="list-style-type: none"> <li>○ This training will be arranged with the support of IMCI Section of DGHS, MOHFW</li> </ul>

<b>Recommendation #21:</b> Concern staff should motivate central-level decision makers to make standards available and use these standards during pre-service training. MHPP should put greater emphasis on the QoC aspect of Maternal and Child Health services being provided at the municipal level..	<ul style="list-style-type: none"> <li>○ We are going to organise a 3 step QoC workshop with the District level Health and Family Planning authority, Municipality and Community. There all the issues will be discussed and agreed.</li> </ul>
<b>Recommendation #22:</b> Establish an accreditation mechanism for QoC across the institutions in which the MOHFW can take the lead in setting the relevant standards or mechanism for voluntary accreditation as done in a number of developed countries.	<ul style="list-style-type: none"> <li>○ Setting QoC at MOHFW level institution by NGOs or themselves is not very feasible. For NGOs it could be possible /feasible. We will discuss the issue during QoC workshop.</li> </ul>
<b>Recommendation #23 –</b> MHPP should calculate the start-up cost for an average-size ward and estimate what it would cost to maintain the health operations in that same ward for a year. The Dhaka-based Promotion/Liaison Officer will require this type of information for both the MOLGRDC as well as donors if large-scale expansion is to take place.	<ul style="list-style-type: none"> <li>○ It is on going and we will complete the task and would disseminate with the relevant authority.</li> </ul>
<b>Recommendation #24 –</b> Concern Worldwide Bangladesh might consider support of long-term training that is directly related to a person’s job and will improve that person’s and project’s effectiveness.	<ul style="list-style-type: none"> <li>○ We will address the issue as per CWB HR policy</li> </ul>
<b>Recommendation #25 –</b> MHPP should train two or three staff persons in QoC and make them responsible for building staff and counterpart awareness and capacities in this aspect.	<ul style="list-style-type: none"> <li>○ We will address the issue and we have a plan for it.</li> </ul>
<b>Recommendation #26:</b> Concern Worldwide Bangladesh should conduct a nationwide survey to determine what a fair and accurate pay scale might look like. Efforts should be made to keep Concern salaries in line with other INGOs. In addition, it should encourage staff to take annual leave days that they earn.	<ul style="list-style-type: none"> <li>○ We will address the recommendation as per CWB HR policy</li> </ul>
<b>Recommendation #27:</b> Concern Worldwide Bangladesh should consider giving annual performance-based salary increments.	<ul style="list-style-type: none"> <li>○ We will address the recommendation as per CWB HR policy</li> </ul>
<b>Recommendation #28:</b> MHPP should retain the five staff members that were slated to leave the project at the end of Year 3 and DIP and budget should be revised accordingly	<ul style="list-style-type: none"> <li>○ Senior Advisor, CWB in consultation with Health Advisor, CW-US will make decision on the recommendation.</li> </ul>