Improving Community Health Workers (ICHW) Project
POLICY BRIEF
May 2020

Strengthening Community Engagement and Local Government Support to Improve Community Health Care Programs

The purpose of this policy brief is to inform discussions and decisions at the national and local levels in Bangladesh regarding why community and government support is essential to improve community health programming. This brief summarizes recent programming implemented by the Improving Community Health Workers project.[1] The brief offers several context-specific program and policy suggestions that the national Government of Bangladesh and local governments can take to improve the effectiveness of their community health programs.

The Challenge

Bangladesh's Community Health Worker (CHW) program is widely recognized as a critical component of the healthcare system and has advanced since the country's independence in 1971. The investments in community service delivery through CHWs have been large-scale, diverse, and adaptable to changing needs. CHWs, the frontline health workforce in Bangladesh, play a vital role in providing primary health care services through engaging community stakeholders in community health care programs. Around three-quarters of Bangladesh's CHWs operate under the management of NGOs, while the public sector employs the rest. Together with the public sector, NGO programs have garnered well-documented achievements in bringing health services to the poor in remote and underserved areas.[2] Nevertheless, questions remain as to how the country can improve its community service delivery and support CHWs to make the best use of their capacity.

[1] Save the Children in collaboration with USAID and UNICEF in Bangladesh supported the Ministry of Health and Social Welfare to implement the *Improving Community Health Workers Project* (ICHW) from 2016-2020.

[2] Arifeen, S.E., Christou, A., Reichenbach, L., et al. (2013). Community-based approaches and partnerships: innovations in health-service delivery in Bangladesh. *Lancet*; 382; 2012-26.

Meeting the Challenge

Community clinics

Back in the 1990s, the Government of Bangladesh embarked on a strategy of establishing Community Clinics (CCs) to address human resource challenges and to bring healthcare closer to the people. The aim of setting up CCs was to move away from the limited scope of household visits by community health workers (CHWs) and other staff and move towards a one-stop comprehensive Primary Healthcare (PHC) Center at the doorsteps of people. Due to a change of Government in 2001, CCs were closed until 2008 when the GOB began to revitalize them. At present, 14,000 Community Clinics are in operation,[3] and the number is increasing gradually. CCs remain challenged by fragmentation of the health system, which impacts the effectiveness of CC operations, including staff shortages, supplies and equipment shortages, and lapses in community support.[4]

CCs are a unique Public-Private Partnership (PPP). All the CCs have been constructed on community donated land while construction, medicine, service providers, logistics, and all other inputs are from Government (GoB), but management is both by community and GoB through Community Group (CG). The community owns the CC and plays an active role in the CCs upkeep and improvement.

There is one CC for every 6,000 people in the rural areas. CCs provide a range of services including maternal & neonatal health care services (antenatal care/postnatal care); Integrated Management of Childhood Illness (IMCI); reproductive health and family planning services; immunizations; nutritional education and micro-nutrient supplements; health education & counseling; screening of chronic noncommunicable diseases; treatment of minor ailments, common diseases and first aid; establishing referral linkages with higher facilities).CCs are staffed by types of staff work at CCs, Community Health Care Provider (CHCP), Health Assistant (HA), and Family Welfare Assistant (FWA). The CHCP is employed full-time at the CC, and the HA and FWA spend 50% of their time at the Clinic and 50% of their time in the community.[5]

The Improving Community Health Workers Project

Bangladesh's Improving Community Health Workers (ICHW) project (2016-2020) offered technical support to the Ministry of Health and Family Welfare's (MOHFW) National Steering Committee on Community Health. Parallel to this, it tested various interventions at the community-level in the project's implementation areas, referred to as a District Learning Lab (DLL). The project was implemented in fifty-four Unions within six Upazilas of the Barishal district.

[3] Source: WHO

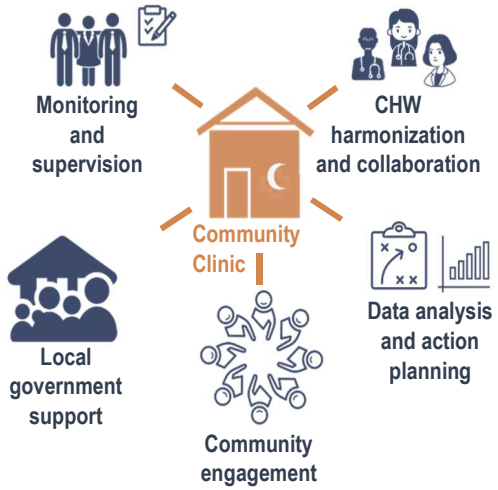
[4] El Arifeen, Shams, et al. 2013. Community-based approaches and partnerships: innovations in health-service delivery in Bangladesh. Lancet 2013 382: 2012-26.

[5] The Bangladesh National Community Health Worker Strategy, 2019 proposes an increase in the amount of time Health Assistants and Family Welfare Assistants would spend at CCs to 60%.

Community Clinic-Centered Health Service Model (CCCHSM)

Consistent with the policy goals of the GoB to advance universal health coverage, the main innovation of the project was the CCCHSM, a model that aimed to improve CHW programs through (1) optimal utilization of CHW potential; (2) increased efficiency of CHW programming; and (3) an improved supportive environment for CHWs through broader and deeper community engagement. The Model is built around the existing MOHFW community health program model and was designed to enable holistic support to community clinic service delivery to strengthen the systems and structures already being implemented through the public health system. It was implemented as a pilot through March 2020 in six Upazilas in the Barishal district with support from the ICHW project to the local Government to strengthen local systems for community-based health services, and at the national level to strengthen policy regarding CHWs and their role. [6]

Figure 1: The Community Clinic-Centered Health Service Model



At the union level, community clinics experience a lack of coordination due to different line authorities for health and family planning, often overlapping or competing NGO roles, the lack of engagement of the local government authorities, and communities. This fragmentation is a barrier to adequate coverage, quality, and rationalized use of resources and services. The MOHFW and ICHW embarked on a process to test the Model in the Barishal District. The objective was to determine if a *CCCHSM* (see **Figure 1**) could contribute to a more coherent and organized approach to CHW programs leading to increased coverage, improved care-seeking, and increased referrals to higher levels of care. The Interventions included enhanced supervision and monitoring of CCs and CHWs, team-building and harmonization of CHW roles and responsibilities, collection of community health data and using it to make decisions and action plans, community engagement, local government support, and an accountability approach (using the Community Score Card process[7]).

[6] Public sector partners in Barishal included the Civil Surgeon, Deputy Director of Family Planning, Upazila Health and Family Planning Officers, Upazila Family Planning Officers, Local Government Representatives. The NGO partner was Partners in Health and Development.

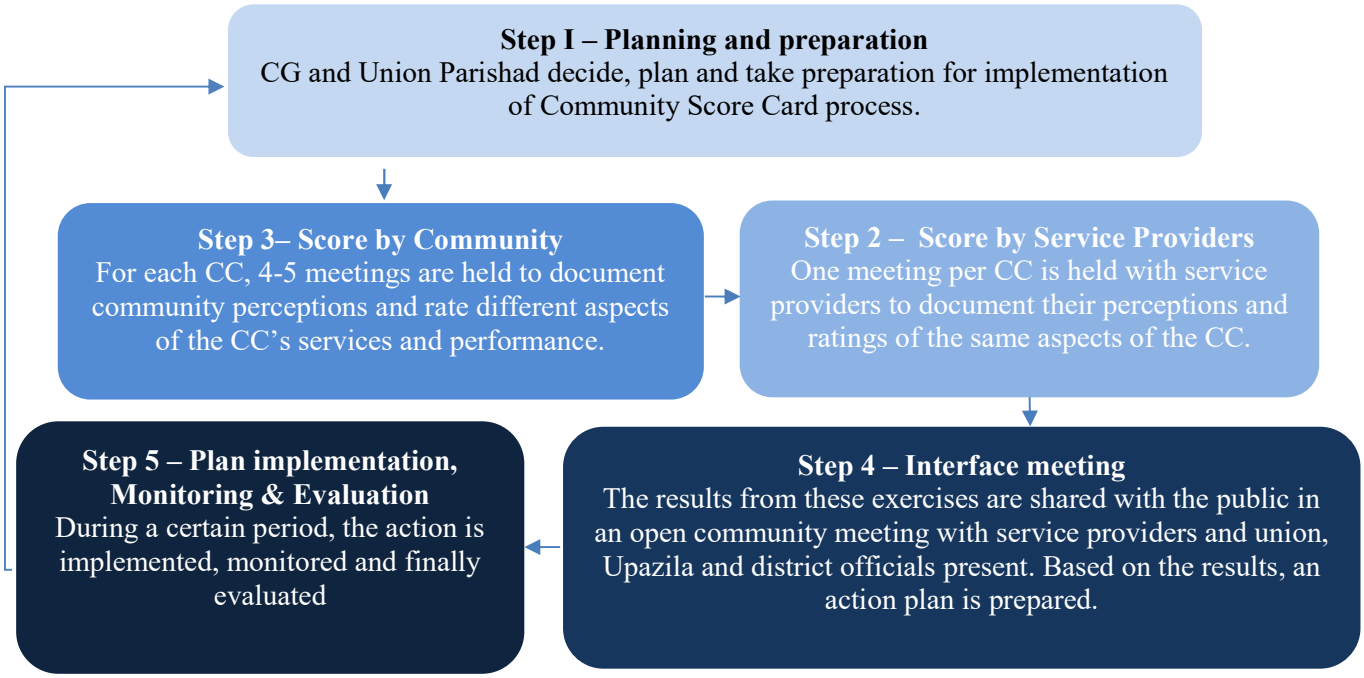
[7] The Community Score Card process enables community scoring of CHWs and overall CC services, and self-scoring by CHWs. This data is jointly developed into an action plan, implemented and monitored between health service providers and community members. The goal is to influence the quality, efficiency and accountability of services at facilities where the CSC was implemented.

Strengthening Union Parishads' involvement and support for CCs Ongoing clinic In each union, the ICHW project activated all the latent Union Health, Education & Family Planning Standing Committees and Community Groups (CGs) and Community Support Groups (CSGs) responsible for CCs.[8] Reactivation of the Committees involved reaching out to the members through the Union Parishad (UP) Chairman, and then educating the Standing Committee members of their official functions regarding overseeing community health systems. In the Community Clinic-Centered Health Service Model areas, local government representatives actively engaged with CGs and CSGs.

In 13 CCs, the local Government used the Community Score Card process to influence the quality, efficiency, and accountability of services at CCs. The Community Score Card process involves community members, CC service providers, and local government officials in identifying issues, action planning, implementation, monitoring, and evaluation of clinic performances. Using the Score Card, CCs are assessed one by one, first by community members, and then by service providers. Each group documents their perceptions about the CC service and its management as well as the challenges and opportunities of their local community clinic. After this, they bring the results together in an interface meeting with local government officials. The process closes with agreement on an action plan for improving the community clinic services and a monitoring system to ensure agreed-upon actions are carried out. Once an initial round is completed, the steps are repeated and integrated into local health management systems for continuous quality improvement.

[8] There are a variety of reasons why these community-led groups become inactive (e.g., absence of leadership, lack of a unifying activity for the group to work on, need for knowledge about roles and responsibilities, and a lack of sense of unity generated by the group.

Figure 1. The Community Score Card Cycle



Short-term results

- Facility cleanliness and provider behavior and skills were noted as key indicators of quality for communities
- Action plans yielded resource commitments from local government
- Scorecard process triggered more involvement from local governments in CC oversight

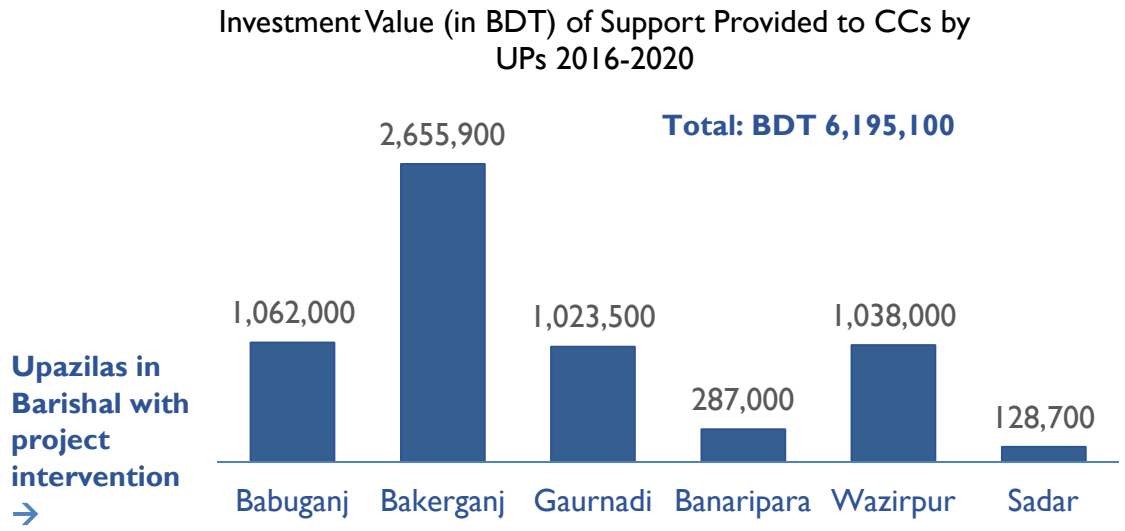
Medium-term results

- Most action plans were implemented, leading to improved perceptions of service quality by clients
- Service providers developed greater responsiveness to clients
- Community members felt empowered to make improvements to the services available to them
- Service use increased

The Community Clinic-Centered Health Service Model enabled both UPs as well as CGs and CSGs to be more involved in CC oversight, enhanced accountability, resource mobilization, monitoring and supervision, which in turn, contributed to the improvement of service delivery at CC level. UP members increasingly engaged with the CCs resulting in resource mobilization and visible structural improvements to CCs (e.g., improving road access, fixing roofs, construction of boundary walls, improving water sources, hooking up electricity connections, installing lighting and solar panels, and furnishing the CCs with furniture and equipment) and staffing CCs with cleaners and night guards. **Table 1** shows the total amount of funds mobilized from UPs throughout the project, by Upazila (as gathered by project staff). The UP bodies started regular oversight and monitoring across most of the 25 CCs in the pilot unions. The project also worked with each CG and CSG to reconfigure membership, ensuring representation across the CCs' catchment areas. Following this, CG and CSG members were trained on their roles (e.g., routine clinic oversight, liaising with community members to share information and promote available services, and mobilizing local resources (both in-kind and financial) for clinic improvements), and began meeting regularly to carry out activities.

Raypashakorapur Union Parishad member **Kadija Begum** is standing on an on the access road she helped secure funding for. Prior to fixing the road, the Dharmadie community clinic was inaccessible for two months due to flooding. Photo credit: Save the Children

Table 1. Investment Value (in BDT) of Support Provided to CCs by UPs during Implementation of the ICHW Project



Findings from the Community Clinic-Centered Health Service Model pilot in six Upazilas in the Barishal District.[9]

Strengthened community engagement and accountability

- Client satisfaction with services increased by 75%
- 20% more CHWs reported oversight from Union Parishad members
- Approximately 85% of local government officials, CGs, and CSGs were able to implement activities in their action plans
- Local governments contributed approximately Bangladesh Taka 2,328,230 to support repairs

Increased use of CC services and strengthened referral system

- Visits to CCs in pilot unions increased by 50%
- The percentage of referred mothers and newborns who attended at a higher-level facility increased from 23% at baseline to 78
- There were 4,455 referrals from the CC to higher-level health facilities for services not available at the CC

Strengthened local government support for CHWs

- CHWs reported an increase of 68% in support from local Government
  86 percent of CHWs reported that local government representatives had monitored their activities compared to 44% at baseline

Increased joint planning

- At end line, all CCs had organized joint planning and reporting meetings in the project intervention areas, a 100% increase over the baseline
- Ninety-five percent of CHWs reported that joint planning between Government and NGO workers had occurred

Strengthened Local Level Data Analysis and Utilization

All CHWs and their supervisors were trained on data analysis and utilization using the Government's DHIS2 platform. At the end of the pilot, 100% of reports by community clinics in the intervention area were posted online and on time.

[9] Please note that findings from the Community Clinic Centered Model were presented to the National Steering Committee in March 2020 and favorably received. The Committee considered the expansion of the Model to other areas as required to ensure its scalability to the diverse populations of Bangladesh.

Call to Action

The results of the Community Clinic-Centered Health Service model and overall development strategy demonstrate that small changes and improved partnerships between the community and facility as well as engagement of local government actors, can strengthen community service delivery. Union Parishads can play an influential role in structural and service improvements for Community Clinics. In addition, activation of Community Groups and Community Support Groups can improve service provision for community clinics.

Program & Policy Recommendations

- ✓ Increase support and integration of health services at the local government level
- ✓ Strengthen participation of communities in managing their health and services in partnership with community-based providers
- ✓ Enhance measurement, accountability and reporting procedures to ensure the quality of community health programs
- ✓ Ensure the dependable availability of resources (financial, logistic, and human) to enable the community health system to meet needs
- ✓ Agree nationally on the range of services that can be provided at community clinics and by CHWs
- ✓ Agree nationally on CHW job description harmonization
- ✓ Improve programs to build CHW capacity for a broader range of services and use of technology
- ✓ Develop training packages for and train a group of core master trainers on the processes of 1) social mapping for CG/CSG activation and 2) the Community Score Card tool to enable other organizations/national entities to initiate their implementation independently
- ✓ Develop an orientation booklet and video training series covering UP responsibilities for community health and CC support that outlines both the national government's expectations and the experiences and results obtained by UP chairmen who worked with the ICHW project
- ✓ Organize and facilitate digitally accessible resource groups of experienced local government representatives, CHWs, and CG/CSG members who can provide remote informal guidance to, and answer questions from, their counterparts in other communities who are beginning the change process
- ✓ Monitor achievements to ensure all efforts are accountable.

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