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Municipal Health Partnership Program (MHPP): Building on Experiences in Saidpur and Parbatipur For Urban Health in Rajshahi Division, Bangladesh October 2004-September 2009

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Acronym List

ADB	Asian Development Bank
ADCC	Assistant Director for Clinical Contraceptives
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CBA	Community Birth Assistants
CHVs	Community Health Volunteers
C-IMCI	Community –Integrated Management of Childhood Illness
CSTS	Child Survival Technical Support
CSSA	Child Survival Sustainability Assessment
DDFP	Deputy Director-Family Planning
DGFP	Directorate General-Family Planning
DIP	Detailed Implementation Plan
EPP	Extreme Poor People
FGD	Focus Group Discussion
FWVs	Family Welfare Visitors
HICAP	Health Institution Capacity Assessment Process
HMIS	Health Management Information System
IMBCT	Inter Municipality Behavior Change Team
IMCC	Inter-Ministerial Coordination Committee
KPC	Knowledge, Practice and Coverage
LAG	Least Advantaged Group
LAMB	Lutheran Aid to Medicine in Bangladesh
MHD	Municipal Health Department
MHS	Municipal Health Staff
MDGs	Millennium Development Goals
MCWC	Maternal and Child Welfare Center
MoHFW	Ministry of Health and Family Welfare
MOET	Management of Obstetric Emergency and Trauma
MOHFP	Ministry of Health and family Planning
MHPP	The Municipal Health Partnership Program
MESPCC	Municipal Essential Service Package Coordination Committee
MOLGRD&C	Ministry of Local Government, Rural Development and Cooperatives
MNC	Maternal and Newborn Care
NSDP	NGO Service Delivery Program
NGOs	Non Government Organizations
PPs	Private Practitioners
PNDA	Peri-natal Death Audit
SSF	Smiling Sun Franchise (USAID flagship program following NSDP)
TOT	Training of Trainers
TTBA	Trained Traditional Birth Attendant
USAID	United States Agency for International Development
UPHCP	Urban Primary Health Care Project-2
UGIIP	Urban Governance Infrastructure Improvement Project
WHC	Ward Health Committees

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Introduction

Concern Worldwide Bangladesh since October 2004 has been implementing a five-year Municipal Health Partnership Program (MHPP) serving seven municipalities (Bogra, Dinajpur, Gaibandha, Joypurhat, Kurigram, Nilphamari and Rangpur), located in Rajshahi Division, Bangladesh. MHPP is supported by USAID's Child Survival & Health Grants Program with a matching grant from Concern Worldwide. The goal of the program is to reduce maternal and child mortality across the seven municipalities reaching 225,000 women of reproductive age and 94,000 children under-five years of age within the five-year period from 2004 to 2009.

The program aims to develop an effective urban health model through utilizing its learning from the child survival projects in Saidpur and Parbatipur. Major program interventions are focused around the primary burdens of mortality: maternal and newborn care, acute respiratory infections, diarrhea, and malnutrition. Training, facilitation, on-the-job learning, and institutional capacity building of municipal authorities and program stakeholders are considered vehicles for achieving program objectives and ensuring sustainability. The MHPP project strategies are:
1.) Foster learning and networking across and within municipalities
2.) Strengthen partnerships and technical capacity between the Municipal Health Departments and private, government and NGO service providers
3.) Build the management capacity of the Municipal Authorities
4.) Support community-led health promotion campaigns emphasizing male involvement, participation, and social support for income poor households.

The purpose of this report is to present the progress towards objectives, identify the key factors behind the progress, review constraints and lessons learned for the fourth year of project implementation (October 2007 – September 2008), and to develop a workplan for the final year of the project. This is a very important period in the life of the project as we hand over and phase out implementation, and position successful components for further replication and scale-up as a contribution to improved health for the urban poor residing in the hundreds of municipalities across Bangladesh.

During this time period, the Concern Bangladesh country office has undertaken a major restructuring, building its program management structure around contexts, including the plight of the urban poor. This decision reflects a profound commitment by the organization to carry forward the learning and experience from the USAID Child Survival & Health Grants Program-supported Municipal Health Partnership Project to the benefit of Urban Nutrition and Livelihoods programs over the next several years. An internal analysis of national mortality shows that the urban poor have the highest child, infant and newborn mortality levels of any geographically defined population in Bangladesh. Over 30% of the population lives in urban areas, and over 40% of these urban dwellers live in extreme poverty. This is the fastest growing population in Bangladesh.

A. Major Accomplishments of the Program

In spite of the political environment and increased economic hardships affecting urban dwellers, most particularly the poor, there were good indications in year four that the project model has taken shape and is beginning to make important contributions to the health of women and children. The following are the major achievements of the program during the past year:

1. Evidence of increased capacity in all seven of the municipalities

Comparative municipal health capacity assessments for 2005-06 and 2007-08 used the Health Institutional Capacity Assessment Process (HICAP). The major mid-term HICAP findings revealed aggregate change at a value of 1 (0.97) in capacity and viability areas across all 7 municipalities. "Leadership" was identified as the strongest among viability areas, while "health policy" was identified as weakest. On average, each of the municipalities achieved one step in progress on a five-point scale, with the exception of Bogra, which remained unchanged. Further details of findings are presented in Annex 1. Commitment by the municipalities was demonstrated by an overall increase of 47% in annual health budget (see Table 1). Bogra municipality alone allocated TK.150,000 for CHVs and WHCs.

Table 1: Comparative annual health budget allocations by municipality, 2007-08 vs. 2008-09

At a glace health budget in the MHPP municipality in Taka				
Municipality	**FY 2007-2008**	**FY 2008-2009**	**Increases**	**Increases (%)**
Bogra	1,850,265	4,050,000	2,199,735	119
Dinajpur	1,982,000	2,842,000	860,000	43
Nilphamari	1,525,000	3,050,000	1,525,000	100
Gaibandha	3,220,000	3,710,000	490,000	15
Joypurhat	5,441,338	7,131,072	1,689,734	31
Rangpur	4,000,000	6,300,000	2,300,000	58
Kurigram	2,871,442	3,623,756	752,314	26
Total	**20,890,045**	**30,706,828**	**9,816,783**	47

Note: 40 Taka = 1 US Dollar

In 2008, all seven municipalities developed participatory annual health plans that reflected community priorities captured by WHC annual plans. The District Health Authority, MCWC, social welfare and women's affairs department, and NGOs were actively involved in the planning process. HMIS data was used in setting EPI targets, and planning for ANC and PNC services.

The participatory, self-discovery nature of the HICAP greatly contributes to the sense of ownership, personal responsibility and commitment that the Mayors and Councilors require to create institutional change. Further, the increased demand for MCH services built by MHPP compelled the municipal authorities to play an active role in coordinating with service providers to ensure the availability of services to everyone. This in part explained the increased budget for health by the municipalities.

2. Maturation of the majority of Ward Health Committees, and significant gains in identifying and protecting their poorest residents

Ward Health committees' (WHCs) capacity assessment tools and methodology are used for strengthening institutional capacity. Under this methodology, five capacity areas -- participatory planning, leadership, M&E, resource mobilization, and coordination -- were identified to provide evidence of capacity status. The 2006 baseline institutional capacity assessment of the Ward Health Committees (WHC) demonstrated that most of the committees' were in 'sapling' stage (i.e. a score of 3 on a 5-point scale). Resource mobilization and coordination was identified as

one of the weaker areas. Review assessment is scheduled in first quarter of Year 5. Considering the weaker areas, the WHCs prepared plans and executed accordingly. As part of these plans, community managed health information management systems were introduced by the ward health committees with the support from Concern Worldwide.

In 2008, WHC meetings and attendance were strong, with 70% of all planned meetings held with at least ¾ of the members in attendance. The role of WHCs are two-fold: first, they take the lead in implementing HMIS by providing supervision and mentoring support to the CHVs; and second, WHCs take the lead in health promotional activities, with support from CHVs, CBAs, and Imams. Promotional activities include observation of health-themed days, educational campaigns, yard discussions, health fairs, and message dissemination. WHCs have also been raising their voices on behalf of the poorest. Slightly more than half (55%) of the WHCs have formal support mechanisms in place for the Least Advantaged Groups (LAG), and the others are in the process of completing the final stage. During the year, a protocol was developed to capture the impact of the WHCs' social and financial support mechanisms for maternal and newborn emergencies. We planned to conduct the study in two steps: desk review of support mechanisms established for the extreme poor and least advantaged groups by the WHCs, including a comparison of findings of baseline asset quintiles and the mid-term KPC HH survey; and an in-depth interview with mothers, KII, and FGDs at community level to triangulate the information (Detailed criteria of LAG with guideline is attached in Annex 8.)

The study will be carried out prior to the final evaluation in early 2009. In the meantime, stories are pouring in regarding how WHC support is saving lives as demonstrated in Annex 7.

3. **Effective leadership of MESPCCs in improving availability of Vitamin A supplements**

A considerable number of decisions were made and executed by MESPCCs in the reporting year. One of the key decisions made at MESPCC level was to ensure regular supplies of Vitamin A to MCWCs for post-partum mothers. Municipalities are now coordinating with District Civil Surgeon offices for Vitamin A supply to MCWCs. Other issues raised in MESPCC forums were: municipal health staff shortages, EPI coverage, HMIS data and its use, etc. Municipalities are submitting the MESPCC meeting minutes to MOLGRD&C on a regular basis.

The issue of Vitamin A supplement availability was raised in MESPCC meetings in Nilphamari, Rangpur and in Gaibandha. The decision was made that from now on each municipality will requisition and supply extra Vitamin A for the MCWCs. Then the MCWCs will ensure the distribution of Vitamin A to every PNC mother. Since these resolutions were made, there have been no Vitamin A shortages at any of the three MCWCs, and the outcomes have been positive.

Strong leadership and coordination of Municipal Mayors and MESPCC chairpersons with district-level decision makers positively contributed to the outcomes. Also, the commitment of the committee members to recognizing and addressing health issues contributed to the formalization of meeting protocols, leading to effective decision making and execution.

4. **Roll-out and use of HMIS and KPC survey data at ward level to improve health coverage (including TT and modern contraceptive use)**

The use of the KPC and ward HMIS data by the WHCs, CHVs and CBAs (community birth attendants) in prioritizing activities and campaigns has been impressive in year four. As of September 2008, 99% of the wards now have a community-based data bank of birth registration

data, achieved by collecting and compiling HMIS basic registration data. Further, municipalities have baseline/mid-term comparative coverage data on key MCH practices and ward coverage gaps. These data have been presented and discussed by each of the municipalities and WHCs for decision making purposes. Here are just a few of the many examples:

- From HMIS data, Joypurhat municipality identified households lacking hygienic sanitation facilities and developed plans for improving sanitation status.
- All seven municipalities are setting EPI targets, including TT based on HMIS data.
- CBAs and CHVs provided individual counseling based on priority indicators to mothers for improving health practices in Bogra, Joypurhat and Gaibandha.
- Bogra and Joypurhat organized satellite clinics on the initiative of WHCs (see Annex-7 case study).
- IMBCT members used KPC data to select priority health behaviors to focus doer/non-doer assessments and develop more effective strategies.
- Nilphamari, Gaibandha municipality has taken a special initiative, in collaboration with MCWCs, to increase use of modern contraceptives.

HMIS basic registration data (2008) shows significant progress in community behavior and social infrastructure. One finding is that as source of drinking water, 18% households are using tap water, and 80% are using tube wells, compare to 7% tap-users and 93% tube well-users according to the 2007 KPC Survey. A significant change has also been measured in the use of sanitary latrines. HMIS data shows that 82% of households are using sanitary latrines, compared to 43% as measured by the 2007 KPC Survey. Use of Khacha (unsanitary) latrines has decreased significantly from 50% to 14% from KPC 2007 to HMIS 2008. Further, HMIS data indicates an increase in TT 2+ coverage to 55%, compared to 47% in KPC 2007, as well as a slight increase in the modern contraceptive rate, from 65% to 69%.

Municipalities felt an utmost need for an information system that included household level information that will be available and visible. With the active support of health volunteers, HMIS was introduced. This management system also measured the number of LAGs within the areas; WHCs utilized this information in developing support mechanism for the LAGs. The availability of data to assess local priority areas (from the lot quality assurance sampling applied in the comparative midterm KPC survey) drove neighborhood level health coverage focus areas. The strength and commitment of the WHC members themselves to in analyzing local data and determining necessary actions to take was also crucial.

B. Program Activity Status

During the reporting period, the Municipal Health Partnership Program has demonstrated good progress towards achieving its objectives. The major accomplishments are presented against the three program intermediate results (IR) and program outputs. Progress on the program M&E plan also complements this section, which demonstrates (Annex-1) major results and utilization of data for the purpose of decision making. This section follows the Detailed Implementation Plan of Year 4. Here activities have been analyzed as per implementation process, and attained outputs are mentioned. This section complements the Major Accomplishments section. Overall progress is good, the workload has been heavy, and a few activities are behind schedule. A complete listing of progress by activity is included as Annex 2.

Objective 1: Sustained municipal health systems for maternal and child health in seven

municipalities

a) Roll-out and strengthen the HMIS in all seven municipalities

Following the pilot of the streamlined HMIS completed in Year 3 in two wards in each municipality, Year 4 focused on reviewing the lessons learned from the pilot and the extension of the system to 60 remaining wards remaining. One ward remains to be completed due to conflict between local politicians in Rangpur. The roll-out was greatly facilitated by the training of 483 "HMIS catalysts" who were selected from among the WHC members (6 per ward, an average of 1catalyst per 20 CHVs). This included basic registration of all households, validity checking and compilation. The catalysts supported the CHV in many ways e.g. WHC provided mobile phone credit to catalyst so that they could easily communicate with volunteers, organise special sessions with volunteers and their parents to smoothen the activities. Key findings (total population count and some health indicators) were shared with WHCs, municipal cabinets and other stakeholders. In HMIS it was found that there is a gap in census and HMIS population. But eventually it was agreed that HMIS data is more valid because they knew how well the household counting was done in each ward.

HMIS Population varies	**Census 01/DIP**	**HMIS**	**Defer No.**	**Defer in %**	Justification for change
Bogra	182,490	132631	49,859	27.3	In HMIS entire population like census was not covered as it did not include students and bachelor service holders, outsider businessmen living in mess, hostel, hotel and floating people due to some social barriers
Dinajpur	175,917	127008	48,909	27.8	
Gaibandha	72,910	54617	18,293	25.1	
Joypurhat	45,966	63724	-17,758	-38.6	
Kurigram	62,826	62479	347	0.6	
Nilphamari	42,297	39724	2,573	6.1	
Rangpur (1 ward missing)	283,448	199124	84,324	29.7	
Total	**865,854**	**679,307**	**186,547**	**21.5**	

To ensure quality and timely compilation of basic registration data, Excel database developed and municipality health staff knowledge on Excel updated by MHPP team. The process has completed in three (Bogra, Joypurhat and Dinajpur) municipalities out of seven due to limited/absence of relevant human resource in remaining areas. In other four areas it was agreed with municipalities that the human resources will be placed in 1st quarter of year 5.

A simple guideline on HMIS implementation was created in Bangla to support municipality actors in overseeing the system. MHPP found an efficient way to train the municipality health staff and catalysts during the HICAP and annual planning workshops. Field observations indicate that the guide has been very useful to the MHS and Catalysts (the WHC members responsible of supporting the CHVs with the HMIS) for following up with the CHVs.

WHCs have functional monthly meetings and have health plans in place. Record shows that 71% meeting was conducted with 76% attendance during reporting period. In year 4, 72 WHCs developed an annual plan (Jan-Dec'08) adopting a participatory process – only two wards in Dinajpur and one ward in Rangpur did not prepare plan due to political unrest. Many WHCs commemorated health theme days e.g. world breastfeeding week, safe motherhood day, etc. and fairs as part of their workplans. These events include rally, posters, yard discussion, and seminar, selection and awarding of ideal parents & healthy baby. The events were attended by

government officials, NGOs, civil society and program participants (CHV, WHC, CBA, Imam) along with the municipality leaders.

Capacity building/skill development for WHC members. While the project aimed to do more than it had achieved, the political unrest in most municipalities made organizing training for the Commissioners challenging and at times unpractical. This year the project organized leadership development and participatory planning training for 125 WHC leaders from 36 wards in Nilphamari, Kurigram, Gaibandha and Joypurhat; organized intra-municipality exchange visits among 35 WHCs; and, organized refresher training for 47 WHCs that reached 740 members on topics identified in the WHC assessments. Great effort was taken so that the Municipality health staff facilitated the training sessions through the existing WHC monthly meeting structure.

Conduct second round of WHC capacity assessments. Planned to start the second round for 4 WHCs this year leading to comparative measures and priority planning prior to the final evaluation. Kurigram municipality completed the capacity assessment but the assessments did not take place in Dinajpur and Rangpur municipality due to non-cooperation of councillors as well as conflict between Mayor and Councillors of those wards.

MESPCC Quarterly Progress Sharing Meeting. Just over half of the planned quarterly meetings took place across the 7 municipalities in year 4. Over ¾ of the members participated. For the meetings that did not take place, the unavailability of the Mayor and/or Civil Surgeon due to competing official government priorities. As noted above, a highlight of the how these groups are working together to improve health services was demonstrated by the Civil Surgeons support to the Vitamin A supply at the MCWCs.

Follow-up HICAP and Annual Health Plan Development. This year the follow-up Municipal Health Institution Capacity Assessment (HICAP) were self-facilitated and lead by trained Commissioners. The HICAPs were conducted in tandem with all seven municipalities' annual planning. The process was facilitated by potentials councillors and health in charge of the municipalities. A supporting guideline was developed by MHPP to support integrated HICAP and annual planning. The HICAP findings are in place and used in annual health plan development. All the municipalities developed the annual health plan timely taking into consideration of WHC annual plan; KPC survey 2007 and HICAP review findings and recommendations of the stakeholders. The planning workshops were participated by Municipal authorities, health department, and district level Govt & NGO representatives. The Councillor's represented the WHCs annual plans during the municipality planning session. They in turn also shared the Municipality annual plan to inform the finalization of the WHC plan.

Skill building for the MHS this year included training of 27 staff on supportive supervision, 76 staff trained in C-IMCI with exception of Kurigram and Gaibandha who were engaged in national birth registration initiative

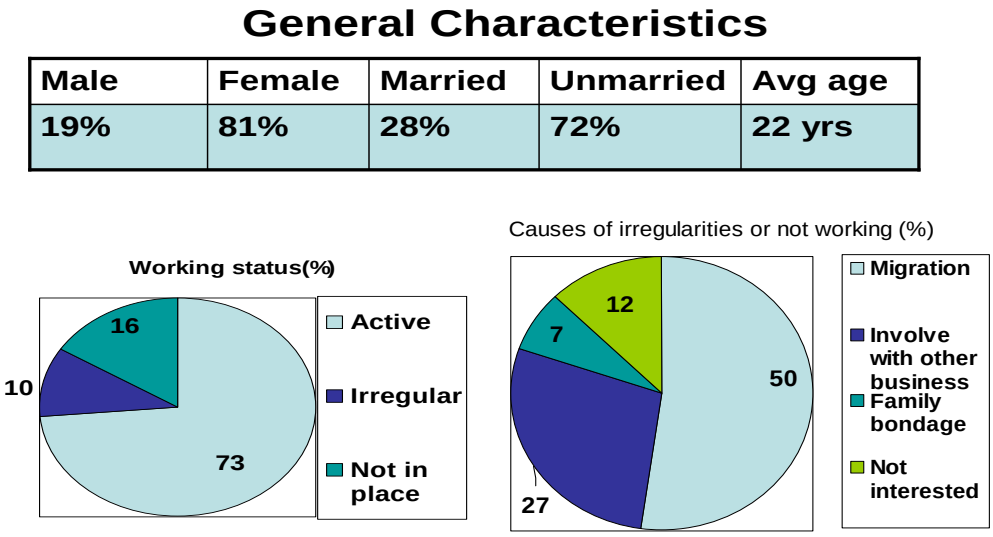
Multisectoral platform. Rather than develop another coordination body, the MESPCC has been expanded and co-opted other non health government and NGOs personnel, e.g. the Islamic Foundation (Mobilize Religious leaders), Social Welfare department and Women affairs department to address issues beyond the immediate essential health services package that contribute to the health of the population.
Further, inter-departmental meetings have been facilitated by MHPP in Gaibandha, Nilphamari and Joypurhat.

Phasing down. In all activities, MHPP is very sensitive to the needs and requirements of the municipalities to continue operations by the end of the project. Throughout, strategies focus on TOT and local skill and leadership transfer, simple guidelines and tools, and consistency with policy.

Objective 2: improved household prevention and care practices for sick children

Increasing availability and skill of CHVs. During the reporting period total 558 CHVs were trained in basic health messages to compensate for the drop out gap. Presently, the total number is 3734. Now 54 households are allocated per CHV. The overall drop-out rate has been 16%. A database has been developed to capture the CHVs drop out rate and emphasis in the transition period will be to help the MHS and WHCs develop a responsive mechanism to replace CHVs. Refresher training is included as part of the bi-monthly meetings and supported by the MHS who are also CHV trainers.

Figure 1: Details of CHV drop-out analysis



Negotiated safer practices by non-formal private practitioners. This year MHPP organized clinical IMCI trainings for seven medical personnel and then six additional personnel were trained as PP facilitators (Note: Joypurhat staff did not attend due to illness). The trainers completed 8 negotiated practices sessions for childhood illnesses focusing on IMCI reaching 245 PPs. In addition, a special national pilot was started in Nilphamari where consultation of homeopaths is most common; a Homeopathic medical officer from Sadar Hospital facilitated this along with MHPP's own Technical Manager for 23 homeopaths. Quarterly follow-up sessions are planned for each municipality and the referral tracking system has been set-up and will be ready for use by the end of this year. The key outcome expected from the Homeopath is to refer the critically ill U5 children to the health facility and also to work on health promotion.

Improving awareness of danger signs and referrals by religious leaders and teachers. Training of Imams was completed with the last batch of 27 leaders trained Dinajpur this year. Refresher training for 351 Imams was delivered as part of monthly meetings during the year. A

special module was developed for Purohit (Hindu Religious Leader) and training was completed for 27 Purohits to better serve the Hindu community on care seeking for mother and children. The Maharaj of Ram Krishna Mission led the development process of the module and his involvement resulted in greater acceptance of the Hindi project participants. A pilot in Gaibandha of 33 school teachers was started and will be reviewed for potential expansion to all six municipalities in year five. The roll-out of a referral tool is under-way and will be introduced by the end of this year. All the religious leaders and teacher modules were shared with the national IMCI section for endorsement.

Objective 3: Improved maternal and newborn care practices in 7 municipalities

Strengthen effectiveness of CBAs. 85% of the 257 CBAs attended monthly sessions at the MCWCs. MHPP introduced a referral slip (see Annex 3 for a copy) this year and the municipalities have taken budgetary responsibility for the printing costs the referral slips. As the referral slips were only recently introduced, the number of referrals is not available yet. The information included in the slips is the causes of referral, referral centres, mother's name etc. The slip contains two parts of which one is left with CBA and other with the referral facility. We are expecting that after introducing the slip more referral will be done by CBAs and that the referred mothers will receive quality services from the facility.

Strengthening Quality of Care. A special review of patient flow at the MCWCs was completed by MHPP this year. The result is being used as an advocacy issue and will be addressed in a quality of care workshop. Discussions have begun with the MoHFW regional QOC official who will co-facilitate the QOC process with the MCWCs in Kurigram and Rangpur in October 2008. The rationale behind the selection of two municipalities was to take a municipality where the maternal and child health indicators are low and the community structure like WHCs are weak. Also we considered selecting one smaller and one larger municipality to compare the effectiveness of the process. Considering all the issues, we selected Kurigram as the smaller one and Rangpur as the larger one.

The project has dropped the originally planned municipality diagnosis for quality of care as it has taken too long to develop the components of the system and the expected support from the Project Advisory Committee is not available. There is a lesson learned here regarding the ability of the model to simultaneously develop municipality leadership, community mobilization as well as take on quality of care across a variety of health providers at the institutional and community levels which should be objectively explored during the final evaluation.

C. Factors that Impeded Project Progress

Project progress was impeded by several factors in year 4 as described here within:

1. Suspension of political activities and volatility. By the nature of their positions, most of the Mayors and Councilors as elected leaders are involved in party politics. Due to the state of emergency, all overt political activities were suspended and a care taker interim government took some steps to bring about positive change in political activities. As a result, in some municipalities Mayors/Councilors have been absent for extended periods; two of them were arrested for different allegations. As the nation prepares for the upcoming elections, a major focus in recent months has been on their preparation including voter ID card development process, Vulnerable Group Development (Government safety net program for extreme poor) and

other safety net program initiated by Caretaker government. Further, there have been frequent changes due to transfers of key government officials in both MoFHW and MOLGRD&C. Under the Caretaker government Chairmen were designated a new title of Mayors and Commissioners were designated as Councilors.

The impact of these events on the project has been significant. The absence of Mayors and Councilors resulted in a local leadership crisis with missed WHC monthly meetings and MESPCC quarterly meetings. CHV Annual progress sharing meeting at municipal level were suspended because municipal leaders were not prepared to host the meetings. Further it was difficult to organize WHC exchange visits. Due to state of emergency, the municipality could not organize CHVs annual gathering. QoC workshop, health facility assessment (IMCI), and PP interventions did not take place as planned due to frequent transfers of GoB officials as indicated above. Maintaining IMBCT gatherings coordinate across municipalities was even more difficult and some members were no longer available. The program decided to focus on the delivery of the action plans that each municipality developed following the doer/non-doer assessments for priority practices.

During this period, MHPP staff and municipal health staff maintained interpersonal communication with Councilors, WHC members and community change agents in order to create a favorable environment in WHC so that members could avoid political discussion in the WHC meeting. At the same time the project team sustained cooperation with alternative leaders of the municipalities as well as government counterpart. Furthermore, MHPP has taken an initiative to strengthen alternative leadership by involving female Councilors (for reserved seats) and placing them in the "driver's seat" of WHCs and by giving leadership to potential members of the committee so that the committee runs smoothly. At the national level, every effort is being made to keep abreast of the transfers of key government positions and to make early contact with their replacements.

2. Overlapping community structures created by NGOs. Within the project area, several NGOs are now implementing health projects and are developing new community structures to support their activities. These are largely parallel in roles and responsibilities to the existing WHCs. In some cases, participants are the same within the different committees. This is very specific to the USAID-funded SHOUHARDO program in Kurigram municipality and the UPHCP-2 in Bogra Municipality. The result is unnecessary confusion, undermining of the mandate of the WHCs and the dampening spirit of volunteerism.

Continuous efforts have been made to overcome problems like conducting meeting with the regional and national offices of CARE and UPHCP-2 to discuss the purpose and scope of the WHCs and MESPCCs and the goals of the other NGOs' programs. It was agreed that the WHC would be an appropriate forum to meet the purpose of the initiatives in question, all looking to reach the poorest and disadvantaged populations of the community. The organizations also agreed that working together to strengthen the WHCs would be the most sustainable and beneficial option for the community.

3. Material and Cash Support by other agencies is putting volunteerism at risk. Core to the MHPP strategy is to provide facilitation and mentoring support to the municipalities and stakeholders for institutional capacity building rather than direct financial support. This approach has demonstrated positive program outcomes over the period, and partners are well acquainted with the MHHP approach. But now several NGOs are implementing health & livelihood projects

partnering with municipalities. These projects have provisions for distributing cash and non-cash incentives to beneficiaries, volunteers and municipality staff and cabinet members. This has provoked the volunteer spirit cultivated by MHPP and raised expectations of receiving cash/non-cash incentives among beneficiaries, volunteers and municipal cabinet members.

The issue was discussed in MESPCCs and WHCs with the participation of SHOHARDO/UPHCP project managers and few practical actions taken such as HMIS basic registration data shared with SHOHARDO/UPHCP instead of collecting these data using paid volunteers. However, the tensions remain and in NGO coordination meeting led by district health authority the issue is raised regularly and progressing towards a common understanding.

The detailed workplan for year five is attached as Annex 4.

D. Technical Assistance Required

In its final stage, technical assistance will be needed in the following areas:

- **Operational manual finalization**. A draft has been developed based on the outline established at the beginning of the project and reflections following project markers. Professional writing support is needed to tailor the level of detail and the presentation of key points to appropriate audience who are primarily project planners. The scope will be revisited as part of the final evaluation.

- **For the final program evaluation** a team leader is required to objectively assess the program's outcomes, impact and lessons learned. The team is particularly keen for the review to include a review of the program's components and their readiness for national scale-up. A well-respected urban health leader is being sought for this assignment. An external firm will be contracted to undertake the final KPC survey. A project-investigator will be required for the five-year post intervention sustainability assessment in Saidpur and Parbatipur municipalities.

- **Support from the Technical Backstop** is needed to follow-up on the phase-down plan execution; explore options for scale-up of the model both within Bangladesh and globally, participation on the final evaluation team as well as contributions to the final operations manual.

E. Substantial Changes

As per the midterm recommendation, MHPP has expanded the definition and measurement of the indicator for rehydration during diarrhea episodes from ORS to also include other rehydration therapies. See Annex 1e for revision.

Specific Activities-Some activities were deducted and some were modified during the reporting period. The following section explains the changes:

- *Project advisory committee*- Considering the context, the PAC activity was removed. There are national Child health committees at both the rural and urban level where Concern Worldwide is an active member and attends regular meeting. An urban health committee of

UPHCP-II exists and could serve this function, particularly for our advocacy initiatives, so we are negotiating to be included as members of the committee.

- *Municipality diagnosis*- The team was not formed due to some specific reasons like inactive PAC, lack of established monitoring of PPs and CBAs, lack of establishment of quality of care activities in health facilities in time. Therefore the project decided not to go forward with this activity in the last year of the project.
- *Teacher training*- Though we proposed to train this cadre in all municipalities, after analyzing their role it was decided to pilot the training in Gaibandha. Based on the result of this pilot training, it may then be scaled up in other municipalities.

- *QoC workshop*- The planned workshops could not happen due to frequent transfers of GoB officials (DG/DD Family Planning) and time constraints. Through discussions, it has been decided that the quality improvement process will be piloted at Kurigram; a small municipality with low quality of MCWC services and Rangpur; a big municipality and high client flow in MCWC. After successful implementation project will advocate with their findings at central level to expand the process within Concern's health and nutrition work.

- The International Urban health workshop planned for year 4 was removed due to the political climate. In lieu, CWB has participated and presented at the International Conference of Urban Health in 2007 and 2008. In 2008, the Project Manager participated in the Concern Haiti Urban Health Midterm Evaluation.

F. Program Sustainability and Phase Over Strategy

From the 3-year post intervention sustainability assessment conducted in October 2007 in Saidpur and Parbatipur municipalities (the original sites where the model was first developed), Concern has demonstrated that with a 98% reduction in external inputs, the municipalities were able to maintain basic operations, and observed only 3% decline in average index value of maternal and child health outcomes, based on 16 practice and coverage indicators. The study confirmed the potential value of an urban health model resting on the Municipality Health Departments and Ward Health Committees, and identified areas requiring attention for successful scaling up. The unpublished article is attached as Annex 9 and was presented at the CORE Spring meeting in 2008.

Based on lessons learned from Saidpur and Parbatipur, before phasing over, the program would expect to see the following: Municipality spends health budget as planned (specify budget lines and money spent accordingly); Newly recruited CHVs receive training from MHD following a plan (at least 1-2 batch per year); WHCs develop annual plan based on health priorities; WHCs support extreme poor to access health care; MESPCCs support extreme poor to access health care; MESPCCs holds quarterly meetings and manages resources; CHVs maintain health promotion and vital registration of 50 HHs; and CBAs continue to refer cases to the maternity.

MHPP midterm evaluation in 2007 assessed the progress towards achieving sustainability in health outcomes. The program initiated some efforts towards sustainability like: 50% WHCs created fund to serve the poorest in emergency medical care with a local resource mapping for fund raising. Also all the municipalities allocated money for WHC. About 30% WHCs set up its office with community resources (land, housing materials). Community changed agents are well accepted for their knowledge and attitude towards health by the community.

In July 2008, the US based technical backstop participated in an internal review of the workplan and critical program transition issues. A basic transition plan was developed and the process of reviewing and action planning with each of the municipality stakeholder teams is underway.

The most critical element that we are focusing on is the replacement catalyst role of a local NGO. The specific desired roles are to engage in monitoring the municipal health budget, facilitate WHC activities and reporting, support the Mayor in convening a WHC Secretaries Meeting twice annually, and nurturing the MESPCC quarterly. The country management has been planning for this since the beginning and had determined that the private USAID supported clinics and their outreach staff were best placed to fill this role. In 2005, an MoU was signed between Pathfinder's NGO Service Delivery Program and Concern and these roles were executed; however, since the change to the Smiling Sun Franchise Program and management leadership to Chemonics last year, this agreement has not been renewed and NGO service providers have been less available to the program, particularly in support of the municipal leadership activities. Updating agreement and clarifying role of NGO Smiling Sun Franchise as liaison with municipalities has been slow to take root. The matter has been discussed with the acting HPN team leader in July 2008 and initial discussions held with Chemonics; however, they have not been able to commit to this role due to financial and time pressures. As a fall back measure, alternate local NGOs have been developed for each municipality and mentoring initiated just in case we are unable to count on the franchise.

G. Addressing MTR recommendations

The following is a list of pertinent recommendations and their status at the end of year four. Recommendation that the project was unable to take onboard have been omitted.

Recommendations	Response
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.	Client flow analysis completed at MCWCs in Rangpur, Bogra and Joypurhat. Bogra MCWC now offering extra one day service for antenatal mothers. See page 8 for further details.
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	This activity was fast-tracked in year four. See page 7.
4. Adopt an indicator for diarrhea treatment that refers to ORT and includes all three forms of rehydration.	Recalculation of indicator from baseline and midterm completed based on expanded definition. Adjustments made in BCC messages.
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.	Engagement with the district hospitals has been tested out in Bogra and Kurigram during year 4, where the MHPP strategy was shared, CHV challenges working with the hospital staff discussed as well as barriers to accessing quality service by the poor. Collaboration and partnership building is ongoing.
6. CHVs should be given books of referral slips so they can refer sick community members directly to the district hospital	The process will be led by Municipal cabinet. The cabinet just initiated discussions with health facilities for establishing such a linkage.
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.	Completed. See page 3.
8. The follow-up HICAP should be conducted as soon as possible to determine progress in the individual	As discussed on pages 1-2, follow-up HICAPs conducted as a part of Annual Health plan for all 7

Recommendations	Response
municipality's capacity and in what aspect(s) they require strengthening.	municipalities.
Rec-9, 10, & 11 Inter ministerial coordinating committee reactivation and advocacy with MOLGRD&C	There have been major changes at the secretary level within the MoLGRD&C which have impeded progress; however, CWB is working on re-establishing relationships. Rather than creating another inter-ministerial committee, we are leveraging relationships with USAID, MoHFW and Asia Development Bank to join as a formal member the UPHCP III Planning Committee which already coordinates between Ministry of MoLGRD&C and MoH&FW. A concept note proposal has been submitted in 2008 to the group and consultations held with USAID and ADB's urban health lead.
12. Analysis Staff deficiency and Requirements at Municipality & MCWC & GoB Hospital, and share the findings in MESPCC meeting	Project team has completed information collection. The analysis will be taken place in next available MESPCC meeting through a participatory approach to draw attention of the authorities.
13. Concern Worldwide should train several trainers in each municipality and they should train all Imams in their respective urban centers	A trainer's pool has been developed for conducting training on Basic Health Messages for Imam at community level. See page 7.
14. Meeting with UPHCP-II at national level	See page 10.
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.	This is an ongoing effort and a key component of the phase-over plan. A tracking system for CHW performance and turnover was developed in 2008 – see page 7
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.	As teachers in general did not have enough time to commit to the HMIS catalyst role, in 2008 MHPP worked with the WHCs to identify 6 members to perform this function. See page 4 for further details.
17. MHPP together with its partners should develop a Phase-Over Package that will guide the transition from project support to self management	The Phase over plan has been prepared and implementation in process for the phase over period of Oct-Dec 2008. A critical point remains clarity of the relations with the Smiling Sun Franchise (refer to page 11). Sit-down reviews were completed with LAMB and UPHCII (for Bogra).
18. Central level meeting with SSF contractors	Concern is in the process of organization a meeting with the new management agency of SSFP; CHEMONICS
19: The DIP should be revised and the training staff at the municipal level should be kept at current levels.	Workplan staffing requirements were carefully analysed with senior management and it was determined that efficiencies in combining meetings with existing trainings and using TOT methods to accomplish project activities with the planned staffing reductions required to enable a gradual transfer of responsibility to the municipality stakeholders.
20: 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.	Could not arrange due to management gap/tension between health and family planning departments at national level but the project is trying to overcome the situation.
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	QoC initiative started in Two municipalities (Rangpur and Kurigram) with the participation of national and local level service providers. Refer to page 8.

Recommendations	Response
Child Health services being provided at the municipal level.	
22: 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.	Determined not to be within the capacity of the current project to undertake as setting QoC at MoHFW level institution by NGOs or themselves is not very feasible.
23: 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.	The cost study objectives and methods were reassessed in July 2008 and a decision was made to limit the study to Concern's cost perspective only. Finance data for 2007 and 2008 has been prepared for analysis.
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.	Recommendations 24, 26-27 all fall under the existing CWB human resources policy. Following the evaluation, internal discussions were held to review underlying dissatisfaction and clarify policies and procedures with MHPP staff.
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.	MNC Technical Manager trained in QOC at JHU trained Project Officers and Rangpur team on basic concepts in 2008.
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.	See response to recommendation 24 above.
27: Concern Worldwide Bangladesh should consider giving annual performance-based salary increments.	
28: MHPP should retain the five staff members that were slatted to leave the project at the end of Year 3 and DIP and budget should be revised accordingly	As mentioned under recommendation 19, a work load analysis was completed and decision made to proceed with gradual staff reductions as planned.

H. Phase Over Plan

Addressed in Section F above.

I. Management System

The Project's **management system** and the factors that have positively or negatively impacted the overall management of the program since inception.

a) Financial Management. Annual budgets are carefully monitored for variances regularly. Increased fuel cost and food item resulted in an overspent in budget. Moreover the implementation of HMIS at 74 WHCs resulted in a heavy cost involvement in project operations. Refer to Annex 5 for budget details.

b) Human Resources. After MTR a participatory workload analysis done by the project team and submitted to the country management. The analysis shows that the staffs which we proposed in the initial project plan were just fine. We initiated the work as per the analysis. Later on a management change process was conducted by country management of Concern worldwide in order to strengthen management capacity by taking different initiatives. As a result of the process some positions have been re-titled for example Program Manager became Project Coordinator.

The field based manager (Operations) were taken out and only one technical coordinator is there to lead the technical interventions. M&E related inputs were placed to M&E specialist of urban program and admin and support officer at urban context has taken over the partial responsibility project support.

In year four several staff capacity building activities took place. On the job training for the staff by the M&E team included introduction qualitative and quantitative research methods, tools and techniques before KPC survey, WHC capacity assessment and HICAP workshop. The project staff effectively used the newly learned knowledge/skills as required. During a quarterly program meeting this year, all staff were oriented on local advocacy and demand mediation. The Sr. Project Manger and two municipality based project managers participated in a management course in Cambodia.

c) Communication System and Team Development.

An effective communication system has been developed allowing staff in all stages decision making of project. In practice, Project team meets weekly and review their last week plan and set the priority for the next week and pass it to the respective line manager. The support team meets at the first day of the week and reviews their agenda for the last week. The Project Management team meets every month to review the progress and plan for the up coming month. The Monitoring & Evaluation Team collect data on program outputs and compare them with project work plans and indicators set in the log frame to measure progress. The program has established a data bank through Health Management Information System. The data generated by the system is regularly shared with the partners and stakeholders for further action. Monthly and Quarterly reports are prepared and shared with the concerned department.

d) Local Partner Relationships. As mentioned, keeping sustainability in the mind from the beginning is key. MHPP has been established through exchanging reviews and sharing ideas for better results of the project. The project actor's like municipal cabinet members, health service providers of government and NGO and community change stakeholders working to develop urban system

e) PVO Coordination/Collaboration in Country

In year four, the Program Manager and Sr. Health Advisor devoted significant time to national and local collaboration with other PVOs, particularly through the national IMCI working group and other maternal and child health for a of the MoHFW. MHPP's activities were incorporated in annual work plan of child health in 2007- 08 and were reviewed in September 2008 and MoHFW appreciated the effort. A national dissemination workshop organized chaired by the Additional Secretary of MOLGRDC to share the result of MTR with the participations from Donors, GOB and NGO and appreciated. Since the inception of the project Concern is closely working with the national IMCI working group headed by MoHFW where UNICEF, WHO, USAID, ICDDR'B, NSDP, PLAN are the members.

*At the project level g*ood relationships have been maintained with Civil Surgeons and Deputy Directors of the Family Planning Department of the MoHFW, LAMB and the UPHC-II in Bogra where the projects overlap. Concern has initiated talks with Chemonics regarding the SSFP continued engagement with the municipalities and the WHCs.

J. Local Partner Organization, Collaboration and Capacity Building

From the beginning MHPP is being fully implemented in partnership with municipalities in the driver's seat, its wing WHCs and local NGOs of NSDP[1] partners. The program also ensured coordination, collaboration and capacity building efforts to district civil surgeon and family planning officials through training, meeting, workshop and planning exercise. Now municipality demonstrate greater role in functioning MESPCC and implementing its agenda through coordination with health facilities. A remarkable change in leadership of municipalities is in place in planning exercise and observing health events involving local health authorities and civil societies. WHCs planning and monitoring exercise has become a regular practice. They also demonstrate some example in raising people's voice to the health facilities for better service and saving lives (Case studies Annex-7). MCWC has ensured easy access of CBAs and CHVs; as a result it has been an appreciative referral point for ward health committees and community channels (CBA, CHV). Refer to major accomplishments in section A which elaborates this further.

K. Mission Collaboration

Collaboration with the local USAID mission remains strong. The child survival focal point, Dr. Shukumar participated in MTR sharing meetings in Dhaka and reviewed the final MTR report. He also is briefed about progress during regular encounters at the IMCI working group meetings.

In July 2008, a formal meeting with held during the US backstops visit with the acting HPN Team Leader and CS focal point to discuss the transition plan and options for national scale-up. The mission extended support to the team for seeking membership in the UPHC-III committee as well as organizing a meeting with Chemonics to look at renewing support of the NGO service providers. The mission has started preparatory work for its next strategic plan and Concern is certainly eager to share its lessons learned and situation analysis findings into this process.

L. Other Relevant Aspects

During this year, key presentation and publications were developed at the Global Level. These include the yet to be accepted for publication article on the 3-year post-intervention sustainability assessment (note this was also presented at a special session at the CORE Spring meeting in April 2008), a poster presentation at the International Conference on Urban Health 200 to be held in Vancouver at the end of October 2008. These documents are shared in Annex 9.

At the National level, MHPP was formally presented to the Secretary General of the MOLGRD&C. Further, a staff presented on the theme of protecting health and climate change at a local seminar in Nilphameri. Of interest is the video documentary produced by a national private television station, Ekushe Television in early 2008 which tells the story of MHPP and central importance of community response to health emergencies. The clip entitle MHPP, Concern Bangladesh Video Documentary is uploaded to You Tube at http://www.youtube.com/watch?v=fnF6CZPDzA4&feature=related

[1] There was a MOU with NSDP. The partnership has phased over in March 2007