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BLOOMBERG SCHOOL
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Lessons from the Ground

A Collection of Case Studies

Save the Children

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Acknowledgements

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PREFACE

As the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh (GoB) is formulating its fourth sector-wide development program for the improvement of health, population and nutrition (HPN), it is timely for development partners, NGOs, and other stakeholders to share insights on lessons learned, innovative practices, and evidence-based models that can be replicated and scaled-up within the country to stimulate demand and improve equitable access to and utilization of HPN services. While aiming to reduce morbidity and mortality, reduce population growth rate and improve nutritional status, especially of women and children, the previous sector-wide programs have seen great achievement, yet certain challenges remain over time—e.g. low rates of deliveries by skilled birth attendants, high rates of neonatal deaths, inadequacies in human resources, and low utilization of public health facilities by the poor. Bottlenecks in the health system result in the sector's need to focus on many of the same priorities with each new development program.

Effective leader-managers at every level in the health system are essential for ensuring that HPN programs and resources are optimally utilized, and strong leadership is key in identifying and addressing bottlenecks in the system. Yet, gaps exist in the leadership capacity of managers at the district level. Many MOHFW district-level managers come into their posts as well-accomplished physicians with strong clinical backgrounds. As they step into the role of ensuring proper implementation of the strategy put forth by the sector program, these managers often do so without prior training in strategic leadership and management.

To help close this gap and ensure managers are equipped with the skills necessary for setting strategic direction and using data for decision-making, the United States Agency for International Development (USAID) supported the Johns Hopkins Bloomberg School of Public Health (JHSPH) in partnership with Save the Children in Bangladesh to establish the Strategic Leadership and Management Training Program for District Managers in Health & Family Planning (SLMTP). Through this program, district and some subdistrict-level managers in health and family planning are provided a 5-day residential course on strategic leadership implemented by the Department of Public Health and Informatics of the Bangabandhu Sheikh Mujib Medical University with the engagement of the MOHFW.

In concert with the development and implementation of the SLMTP, JHSPH and Save the Children in Bangladesh, with funding support from USAID, embarked on a documentation activity with the aim to profile examples of innovative practices, particularly in MNCH, that could highlight keys to successful implementation and lessons learned in leadership. In particular, there was a need for documenting and sharing strategies that help address common bottlenecks, and can be replicated across the country. The resultant profiles are used within the curriculum of the SLMTP leadership course and refresher activities and are presented along with associated case study exercises that encourage discussion and problem solving. In publishing these profiles in booklet form, it is our goal that the lessons learned might be shared more broadly beyond the SLMTP course; that stakeholders across government, NGO, and private sectors find the lessons applicable and incorporate them into their own work.

This documentation effort is a small contribution to continued dialogue within the Bangladesh health sector that promotes the improvement of health programs, innovations, and strategic leadership to address bottlenecks. There are many other long-standing and new programs and strategies that could not be included in this educational effort. To help further the dialogue, at the end of each profile we have suggested additional programs similar to the one profiled which could also be considered for detailed documentation. We hope to see many stakeholders continuing to try new strategies to address bottlenecks, disseminating innovative practices, and learning from each other's successes and challenges.

Photo: Save the Children/GMB Akash

METHODOLOGY

The five profiles presented in this booklet resulted from a year-long process to identify, narrow, and document nominations of good practices that show innovation and have the potential to share key lessons in leadership and successful program implementation, particularly within the context of maternal, neonatal, and child health. A national online survey was conducted in January 2014 through which stakeholders in government, development partners, and NGOs provided suggestions on priority thematic areas for the documentation activity, gave input on the criteria used for selecting good practices, and provided nominations to be considered. This was followed by a national-level workshop held in February 2014 in Dhaka, where stakeholders reviewed and discussed the preliminary nominations.

Following the workshop, the documentation team comprising Johns Hopkins University Bloomberg School of Public Health and Save the Children in Bangladesh staff met individually with each nominated organization to collect program documents (e.g. annual reports, M&E reports, program manuals, toolkits, brochures, concept notes, etc.) for review. Using a scorecard largely based on the World Health Organization's criteria for identifying best practices and modified during the stakeholders workshop, three team members individually scored each nomination. In addition to traditional best practices criteria, the scoring process also took into consideration the availability of program documents and data, and whether the practice was already broadly disseminated. The reviewers' scores were averaged and used to determine a shortlist of nominations that were best fits for the documentation activity. A smaller team of key stakeholders was consulted to provide feedback on the proposed shortlist, and five were selected as feasible to profile within the existing scope of the documentation activity.

The documentation team made multiple visits to the sites of the selected programs, collecting additional program materials, conducting in-depth interviews and focus group discussions, and documenting activities through photographs and video. The team found it useful to collect primary data for each of the profiles, in order to highlight aspects of the practices not routinely available in program monitoring data and evaluation reports.

ACRONYMS

ANC	antenatal care
BCC	behavior change communication
BDT	Bangladeshi taka
BNC	Bangladesh Nursing Council
BPATC	Bangladesh Public Administration Training Center
C-IMCI	community integrated management of childhood illnesses
CBO	community based organization
CCC	Central Cooperative Committees (of People's Institutions)
CEmOC	comprehensive emergency obstetric care
CHV	community health volunteer
CHW	community health worker
CmSS	community support system
CNG	autorickshaw (baby taxi) that runs on compressed natural gas
CPAP	continuous positive airways pressure
CS	Civil Surgeon
CSG	community support group
CSO	civil society organization
DDFP	Deputy Director Family Planning
DFID	Department for International Development (UK)
DGHS	Directorate General of Health Services
DORP	Development Organization of the Rural Poor
EmOC	emergency obstetric care
EPI	Expanded Program on Immunization
ESD	Essential Service Delivery
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
GSK	GlaxoSmithKline
HA	Health Assistant
HMIS	health management information system
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
JICA	Japan International Cooperation Agency

KMC	kangaroo mother care
LBW	low birth weight
LTC	LAMB Training Center
M&E	monitoring and evaluation
MBBS	Bachelor of Medicine degree
MDG	Millennium Development Goal
MIS-R	management information systems and research
MNCH	maternal, neonatal, and child health
MOHFW	Ministry of Health and Family Welfare
MOU	memorandum of understanding
NGO	nongovernmental organization
NVD	normal vaginal delivery
OGSB	Obstetric & Gynecological Society of Bangladesh
P-CSBA	private community-based skilled birth attendant
PARI	Participatory Action for Rural Innovation
PG	Primary Group (of People's Institutions)
PI	People's Institution
PNC	postnatal care
PPP	public-private partnership
QIT	Quality Improvement Team
RMO	Resident Medical Officer
SATHI	Sustainable Association for Taking Human Development Initiatives
SBA-CP	skilled birth attendant-community paramedic
SMPP-2	Safe Motherhood Promotion Project Phase 2
SSC	secondary school certificate
TBA	traditional birth attendant
TTBA	trained traditional birth attendant
UFPO	Upazila Family Planning Officer
UH&FPO	Upazila Health and Family Planning Officer
UNO	Upazila Nirbahi Officer
USAID	United States Agency for International Development
WIT	Work Improvement Team

photo: Save the Children/GMB Akash

PEOPLE'S INSTITUTIONS MODEL

World Renew (With local partners PARI and SATHI)

Purpose: To reduce mortality and improve health status among the most marginalized mothers and newborns through improving household and community MNC-related health behaviors and increasing utilization of quality services for hard-to-reach families and communities.

Approach: The People's Institutions (PI) Model comprises community groups at the village, union, and sub-district level that mobilize marginalized community members for health promotion and social change while strengthening public-private partnerships in support of MNCH. These groups build local capacity to identify and address community needs; empower the poorest and most marginalized populations to make decisions; mobilize local resources for health; motivate communities to advocate for policy changes to respond to their needs; and establish and strengthen linkages between communities and health facilities to improve quality, availability, and access to health services.

Positive Change: Using the PI model to mobilize marginalized populations and implement MNCH promotion activities has been shown to significantly improve a community's social capital, improve communication and networking with government health facility managers, increase access to government and private sector health and social services, and improve maternal and neonatal health practices and outcomes. Lessons learned from the PI model should be incorporated into the Ministry of Health and Family Welfare's Community Clinic Support Groups across the country.

A meeting of a People's Institution

photo: Save the Children/GMB Akash

BACKGROUND

Netrokona District is one of the Government of Bangladesh's (GoB) 14 low performing districts. In this poor, remote district with a large indigenous population, health facilities are sparse and maternal and neonatal health indicators are consistently lower than national averages. World Renew, an international Christian NGO that has been working in Bangladesh since 1972, has over 18 years experience helping communities establish People's Institutions. Through their USAID-funded SUSOMA Project (2009-2014), World Renew worked with local NGOs in two subdistricts of Netrokona District—Participatory Action for Rural Innovation (PARI) in Durgapur Upazila and Sustainable Association for Taking Human Development Initiatives (SATHI) in Kendua Upazila—to employ the PI model with the aim to improve maternal and neonatal health. Furthermore, they conducted operations research and a formal program evaluation to better understand the mechanisms through which the model effects social change in communities ultimately leading to improved health outcomes, and to make recommendations for scale-up of the model.

photo: Save the Children/GMB Akash

PARI Community Health Trainer, Senuka Sangma, meeting with a community member in Birishiri

PEOPLE'S INSTITUTION MODEL STRUCTURE

The 3-tiered People's Institutions Model comprises community groups at the village, union, and upazila levels that correspond to the levels of the health system with which they interact [see diagram below]. Within each group, members form various committees to oversee program activities and elect members to an executive committee that changes leadership every two years. The vision for these groups is that they become fully institutionalized, independently operating, sustainable self-help groups able to mobilize resources and relationships to positively impact the development and health of their members and the broader community.

Primary Groups (PG): At the village level, groups of 15-20 members each meet weekly. Women and men form separate Primary Groups, ensuring equal opportunity for women to develop their leadership capacity and confidence before joining mixed groups at higher tiers where they feel empowered to fully participate in decision-making. Each village may have approximately 2-4 separate Primary Groups.

Central Cooperative Committees (CCC): One to two representatives from each Primary Group come together to form Central Cooperative Committees (CCC) at the union level, which have mixed women and men membership. Each CCC meets monthly and oversees the activities of the approximately 20 PGs it represents.

People's Institutions (PI): Two or three representatives from each CCC then form the upazila-level People's Institutions (PI) which also meets once per month and has mixed women and men membership. Each PI represents five to ten CCCs. The PIs exist to oversee the work of all the lower-level groups within the upazila and to build strong public-private partnerships between the community groups and the government health system.

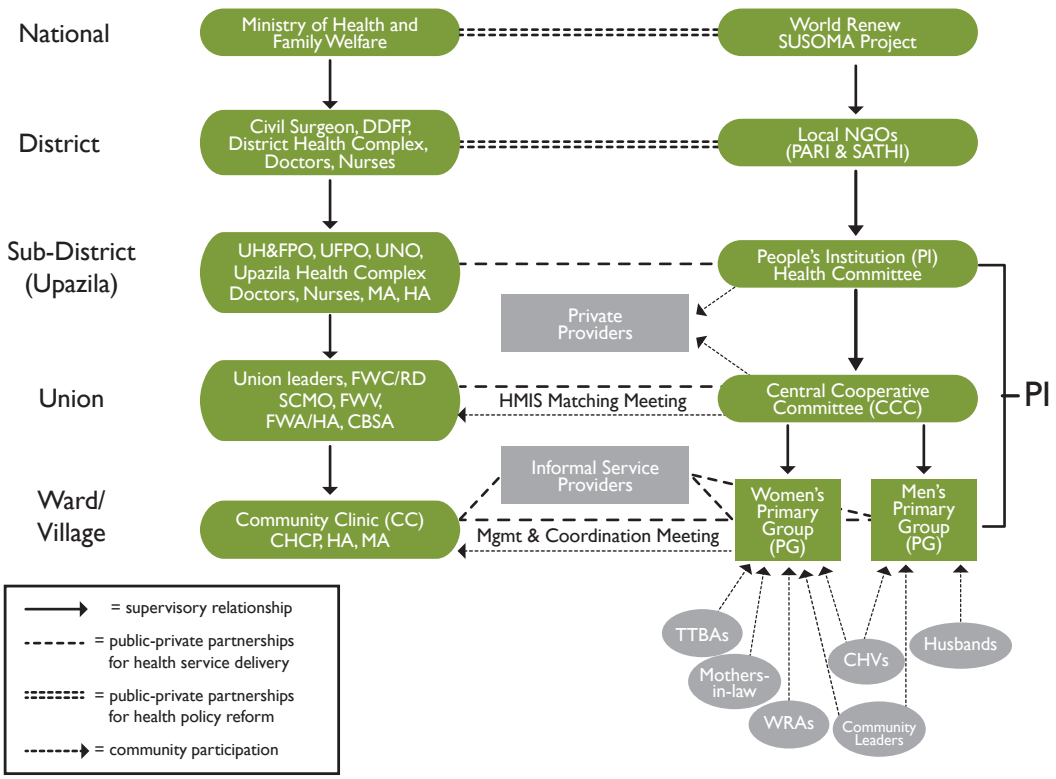

photo: Save the Children/Erin Hunter

"Group leaders are selected based on their dedication, service mentality, time availability, and skill—those who sacrifice. Good people do not deprive others. Good leaders are known by their good work. Our members know well that leadership is like motherhood. As a mother saves her child by any means, a leader should be like this. The leader who is interested about money cannot survive here."

Project Coordinator, local NGO

ESTABLISHMENT OF PEOPLE'S INSTITUTIONS

World Renew's two partnering NGOs, PARI and SATHI, utilized their local staff to motivate poor, marginalized community members to form PGs in their villages. During a 3-6 month "pre-group phase," interested community members began meeting together weekly with staff from PARI and SATHI who served as catalysts to promote the development of shared visions for the groups and discussed the opportunities for training that would be made available to those who chose to officially place membership. This pre-group phase ensured that all members had time to fully understand what membership in a group entailed and that they were motivated to commit themselves to full participation. This period also allowed time for trust to develop among potential members and the facilitating NGO staff before group members began contributing weekly savings. Over time, leaders naturally emerged within the groups and PARI and SATHI facilitated those individuals to form union-level CCCs and then upazila-level PIs.

PARI and SATHI worked with each group to identify their own set of capacity indicators and scoring system to monitor their development as a group over time in regards to leadership and management, legal identity, gender equity, finances, stewardship, and networking. Groups reviewed their progress against the indicators every six months. When lower tier groups demonstrated strong enough capacity according to each indicator, they graduated from the oversight of the local NGOs and were overseen solely by their upazila-level People's Institution. When PIs demonstrated strong enough capacity, they graduated from the NGO's oversight and registered with the government to become fully independent Social Welfare Societies.

"Our neighbors observe that we are conducting weekly meetings and collecting savings. If anyone faces any problem, we assist them with these savings; we do not need to go to the local elites anymore. We utilize our savings ourselves. In this way, cooperation, kindness, unity, everything has increased among us."

PI member

MNCH ACTIVITIES OF PEOPLE'S INSTITUTIONS

Once a group is officially established, members form themselves into committees and the local NGO facilitating their establishment provides group members with opportunities to participate in capacity building training on health promotion, leadership, management, record keeping, gender, local resource mobilization, M&E, auditing, sustainability, advocacy, networking, and capacity measurement. Members collect savings during their weekly meetings, raise funds within their local community, and some groups take their own initiative to start small business ventures to generate additional income—for example, renting out tables and chairs for events within their villages. These savings contribute to a group's emergency health fund (EHF), which is used to improve equity in health service access by subsidizing costs of emergency transport and life-saving interventions for members of the group and the wider community when the need arises.

The health committee of each group oversees all health-related activities including the hosting of BCC drama events, participation in national health and immunization days, and facilitating MNCH-related training for group members and members of the broader community. Each Primary Group nominates at least one member to be trained as an unpaid community health volunteer (CHV) who then becomes responsible for promoting health within the village through providing household and group counseling, identifying maternal and newborn danger signs, referring to health facilities, and working to sensitize informal service providers to reduce harmful MNCH practices. Furthermore, Primary Groups identify existing traditional birth attendants in their villages and link them with training on clean delivery, referrals for complicated pregnancies, and immediate essential care for mothers and newborns after delivery. When community members cannot afford to access health services, groups lend money with low interest rates (or often interest-free) from their emergency health funds.

Parvin Sultana, a Community Health Volunteer, providing service to Morshida in Bhuligaon, Birishiri

Health committee members take responsibility for building strong relationships with government health facility managers to establish lasting public-private partnerships (PPP) at each tier in the system. PIs and government health facility managers sign MOUs and meet monthly to discuss the health needs of the community and strategize how they can work together to ensure sufficient provision of quality health services. They also hold monthly HMIS matching meetings during which they share community MNC surveillance statistics collected by the PI groups' CHVs and TTBAs and merge these data with those collected by government workers. These matching meetings ensure more comprehensive identification and tracking of pregnant women and MNC outcomes in the community and provide opportunities for PI members to follow-up on cases referred to government facilities. Furthermore, PI members are included in the government-instituted management committees for all government health facilities, which enables group members to be directly involved in clinic decision-making and advocacy.

"PIs supported us in regards to the list of pregnant women. Sometimes our government workers may not know where there are pregnant mothers. The PI members are community people, but our workers are salaried staff fulfilling job requirements. PI members however don't receive any salary; they work voluntarily. When people come and say 'I want to voluntarily give this service,' then you have to understand that their aim is noble. We have received huge support from the PIs; they have referred a large number of patients to us."

UH&FPO, Durgapur

A HMIS matching meeting

photo: Save the Children/GMB Akash

PI MODEL'S CONTRIBUTIONS TO MNCH

» Strengthened public-private partnerships in support of MNCH
  - Poor and marginalized community members are better able to access public services through the help of PI's emergency health funds
  - PI groups have established strong functional ties with GoB and communicate regularly with facility managers

» Improved MNCH practices of mothers and families
  - Increased 4+ ANC visits, deliveries assisted by CSBAs, facility births, newborn and mother PNC visits, and exclusive breastfeeding, among other improvements

» Increased quality of MNCH services
  - Increased rates of clean cord care, use of clean birth kits, and appropriate thermal care of neonates, among other improvements
  - Increased referrals and priority treatment at facilities for those referred
  - Clinic service availability increased
  - Better coverage of MNCH training for government health workers

» Enhanced enabling environment
  - Monthly HMIS matching meetings between PIs and government personnel ensure more complete records of maternal and neonatal data from the community
  - Advocacy has resulted in numerous documented examples of policy changes that have benefitted the poor

"PI members requested us to take special care of those whom were referred by the PIs. If any of their referred patients did not get special care, they would face an embarrassing situation in the society. That is why we always tried to treat [the referred patients] with greater attention. We wanted to highlight them in the society."
UH&FPO, Durgapur

EXAMPLES OF IMPROVEMENTS ACROSS SELECTED MNCH INDICATORS

Indicator	Baseline 2009	Endline 2014
4+ ANC visits	5.3%	13.6%
Deliveries assisted by CSBAs	9.3%	21.9%
Facility births	8%	19.3%
Newborn PNC	10.7%	15%
Maternal PNC	8.6%	18.5%
Exclusive breastfeeding	47.2%	52.9%
Clean cord care	57%	69%
Use of clean birth kits	4.2%	32%
Thermal care	9.7%	40.2%
Percent of sampled facilities receiving referrals	37%	80%
ANC available at GoB facility 4x/month	60%	90%
GoB facility staff training in MNC in past 12 months	3%	53%

KEYS TO SUCCESS

Team management approach: PARI resists hierarchical management and instead uses a team management approach in their organization and programs. The Executive Director refers to himself as "Team Leader" rather than "ED," and the majority of decisions are taken by the team. All staff meet together regularly to report on their work, share challenges, and establish committees to look at problems. All staff are empowered to network with program partners and government officials; and financial matters are kept transparent to foster trust among team members.

Relationship building: The local NGOs facilitating the establishment of People's Institutions focused on building trusting relationships with community members during the formation of the groups by listening to the community, facilitating the development of shared visions for the groups, and acting as catalysts for action rather than dictating regulations. These NGOs then modeled how to build strong relationships with other stakeholders, local leaders, and government personnel. Phone numbers were shared among PI members, facility managers, and NGO staff to ensure open lines of regular communication, and trust was built as UH&FPOs and UFPOs observed PI members' dedication to their voluntary work and the synergistic effects of the public-private partnerships.

Group member selection: PIs have very low attrition rates because of the membership self-selection process. When forming community groups, a 3-6 month "pre-group phase" allows potential members enough time and information to make informed decisions about placing membership. This may ensure only the most committed and motivated individuals join the groups, leading to higher productivity.

Pictorial HMIS forms for illiterate community workers: The local NGOs and government staff jointly developed a pictorial HMIS form so illiterate CHVs and TTBAs were still able to collect village-level data on pregnancies, births, and deaths to merge with the government's HMIS records.

"Our staff members sit next to program participants, not in front."
Executive Director, PARI

"We emphasize networking at various levels—from the community level upwards. Relationship building, networking, and how to maintain it. They want to do their best. Their mentality, skills, and ability, we want to utilize. We give them inspiration and they take it as enjoyment. Saving people's lives, making people aware is now a source of happiness for the PIs."
Health Coordinator, local partner NGO

"If a person comes to me and tells me 'Sir, I want to assist you,' I should receive this assistance. It should be gladly accepted when I find they are indeed doing good. There are many NGOs who are found only taking pictures during special days. But PARI always communicated with us and helped mothers with emergency funds; and if there were any gaps found in the Community Clinic, they followed up. We have limited resources and they helped us a lot."
UH&FPO, Durgapur

"We could overcome many problems because of the UH&FPO's and UFPO's support. They provide services to sick people and work alongside us. They do their job and have accountability in their work. Our work differs a bit. It is difficult for the government to collect grass root information, so we collect that information and send it to them and they take steps based on it; in this way we assist each other."
PI member

RECOMMENDATIONS

1. The PI Model is associated with improved MNC health practices and higher quality of MNC services and therefore should be considered for scale-up in rural poor communities in collaboration with government officials interested in improving MNCH services and outcomes.

2. Learnings from the PI Model should be applied to the Ministry of Health and Family Welfare's Community Clinic Support Groups, particularly in regards to group formation strategies and the "pre-group phase."

3. Duration of programs instituting the PI Model in new communities should be longer than 5 years in order to fully incorporate support mechanisms for groups and ensure sustainability of the model and resultant health gains.

FURTHER EXPLORATION

Other models of successful community mobilization groups are active across Bangladesh. Although we have been able to provide a glimpse into just one example, we recommend further documentation highlighting lessons learned from the following models, which could yield additional insights into the keys for successful implementation and sustainability:

- Community Action Groups (Save the Children)
- Community Support System (CARE Bangladesh)
- Community Support Groups and Community Groups of Community Clincs (MOHFW)
- Mother's Groups of the Perinatal Care Project (Diabetic Association of Bangladesh)
- Child Centered Community Development Approach (PLAN)

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photo: Save the Children/GMB Akash

Bottom-up Health and Family Planning Budget Monitoring

Development Organization of the Rural Poor (DORP)

Purpose: The chronic unavailability of essential health services in many areas of Bangladesh is one of the country's major public health challenges. One of the underlying causes of inadequate service provision is the gap that exists between health and family planning budget allocations from the central government level and subsequent disbursements to lower levels, and between the disbursement amounts and the utilization of funds at the implementation level. While local health and family planning officers try to manage with fewer resources, their communities remain unaware of the government's commitments to health and their own rights to request insight into budget issues. Bottom-up budget searching and service monitoring activities help identify and address these gaps.

Approach: Locally-formed budget clubs work to raise awareness within their communities about individuals' rights to access high-quality essential health and family planning services and mobilize community members to become involved in advocacy concerning health services and family planning budget issues. The budget clubs regularly communicate with managers in their local health and family planning facilities to track the funds received from the central government, make comparisons to the allocated amounts according to official budgets, and to monitor the facilities' service readiness and quality. Club members review the data to identify gaps and work alongside government personnel to strategize ways to advocate for missing funds to address the community's health needs.

Positive Change: Frequent meetings among health and family planning facility managers, representatives of budget clubs, and union standing committees have resulted in improved understanding and trust between health service providers and recipients. Using data, budget clubs have successfully advocated for improved health and family planning services in their communities.

Budget club member Md. Mohabbat Alam "Biddut" collects information at a local family planning facility

photo: Save the Children/Hasan Bipul

BACKGROUND

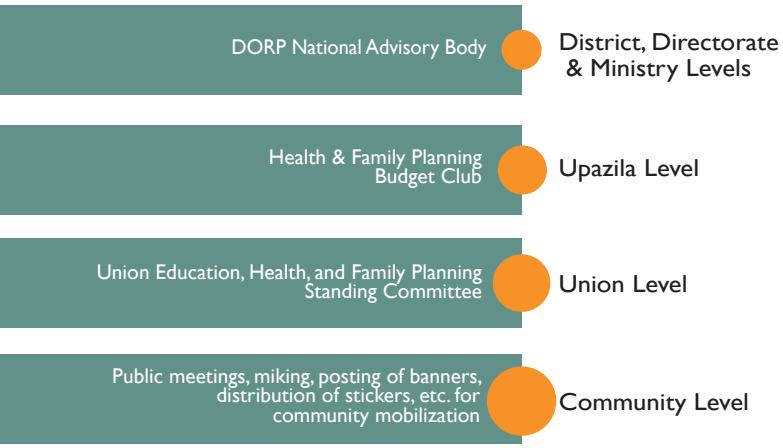
photo: Save the Children/Hasan Bipul

In Bangladesh, the annual total health care expenditure per capita is $27,[1] well below the World Health Organization's recommended minimum necessary for adequate fulfillment of the health system's essential functions.[2] Bangladeshi households pay 63% of healthcare costs out-of-pocket,[1] which in a country where the majority of citizens live in poverty, results in inaccessibility to services and the risk of further impoverishment during medical emergencies. While health expenditure in Bangladesh has increased substantially in the last decade, the health sector is still underfunded and plagued by inefficient use of existing funds.

Under the existing system, budget development for health and family planning is highly centralized and does not always reflect the needs of local communities. Resource allocation for health is based on the number of existing hospital beds in a region, while allocation for family planning is partly facility-based and partly based on the number of potential users. Gaps exist between the funds allocated at the central level and the amounts actually disbursed to the lower levels, and then again between disbursed funds and the amounts utilized at the local level. Allocations from the central level are already too low to properly fund quality health and family planning services, yet even the funds that are allocated are underspent. As a result, essential health services are inaccessible to many, while local communities remain unaware of their rights to such services and their government's commitments to health.

Development Organisation of the Rural Poor (DORP), a Bangladeshi NGO, has long advocated for pro-poor health policy and financing, but officially began a health and family planning budget monitoring project in 2006 in six upazilas located in six different districts (Kamalnagar, Kaliakoir, Kamalganj, Lohagara, Bakerganj, Sirajganj). Through this initiative, DORP began to support a system of local bottom-up budget searching and tracking in order to empower communities with awareness about the financing of health and family planning services and to advocate for better utilization of funds for improved implementation of Essential Service Delivery. This process involves a review of documents to "search" for health service and family planning budget allocations made at the central level and comparing them to what is actually disbursed and then utilized at the local level. The process also involves assessing service readiness and quality at union and upazila-level government health and family planning facilities, and mobilizing community members to work with their local government officials and health and family planning managers to ensure all available resources are optimally utilized. DORP's National Advisory Body further supports these efforts with national level advocacy and lobbying in order to address constraints at higher levels of the government.

PROJECT STRUCTURE



Working with a project budget of just €15,000 funded by the WEMOS Foundation (Netherlands), DORP partnered with one civil society organization (CSO) in each of the 6 project sites which in turn engaged community members through two platforms: Union Education, Health, and Family Planning Standing Committees of the elected Union Councils, and Health and Family Planning Budget Clubs at the upazila level. Initially, many Union Education, Health, and Family Planning Standing Committees were not functional, so the CSOs successfully advocated for their formation and supported the reactivation of their activities. At the upazila level, the official Hospital Management Committees chaired by the local MPs were largely inactive and had no provision for public representation. For this reason, DORP's partnering CSOs facilitated the establishment of a Health and Family Planning Budget Club in each of the six project upazilas, comprising civil society representatives as an alternative body to lead the budget monitoring activities. These two platforms were responsible for monitoring health and family planning services at the union and upazilas levels, identifying areas of concern, and consulting regularly with the government's health and family planning managers and local government officials to ensure their communities' needs were being met by service providers.

Photo: Save the Children/Hasan Bipul

Budget club meeting

ESTABLISHMENT OF BUDGET CLUBS & DATA COLLECTION TOOLS

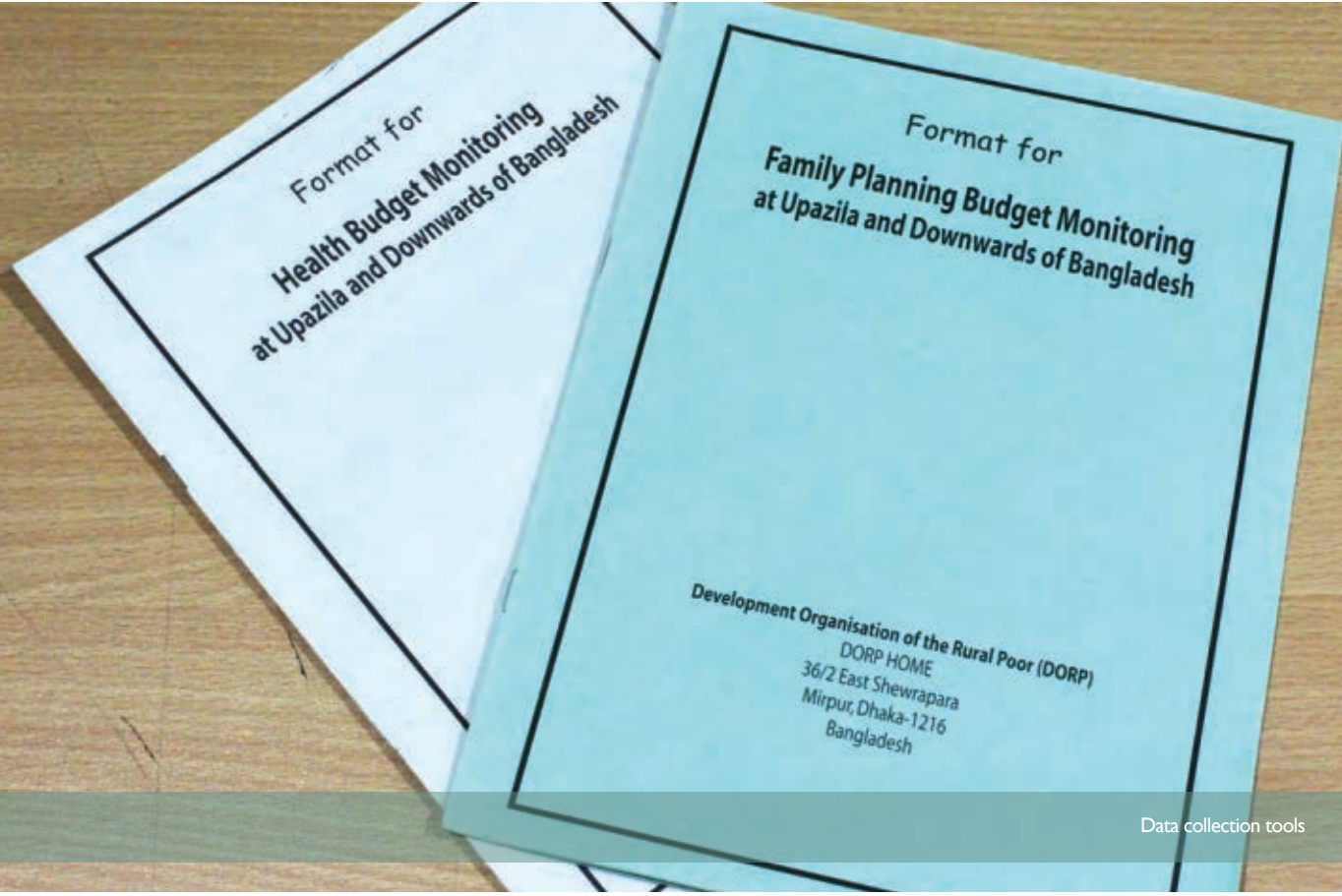
"We knew all along that we would work voluntarily and would not be financially benefitted from it; and we developed ourselves accordingly. We had people from various backgrounds and professions. For instance, I am a journalist. There was a freedom fighter, a teacher. It was a diverse group with people from all paths of life. I had really good rapport with the Civil Surgeon. I was able to convince him and he also gave my idea a priority. So as our advocacy grew, the topic received more importance and eventually it became a success. The people of the *chor* areas personally told us that no health officer or health provider had visited their areas. They never knew any one of them. But now through us, they got to know them and started receiving services."

Budget Club Member

Members of the local CSOs that facilitated the budget clubs' establishment at the upazila level were intimately familiar with the local communities and were thus able to mobilize influential and well-respected community members from a diverse range of professions to form the clubs. Club members feel a sense of social responsibility and possess varied skillsets that ensure their success in advocacy efforts. Members explore their own networks and leverage personal contacts in their respective fields to contribute to the work of the budget club.

photo: Save the Children/Hasan Bipul

Sufia Khatun, a budget club member, speaks about maternal and child health issues in her community



Data collection tools

After years of deskwork and informal information gathering to better understand the health service and family planning budget process and financial flows, DORP was able to develop standardized data collection tools to aid its partners in regularly monitoring the budgets and service readiness indicators at their local health facilities and family planning centers. These tools were finalized through national level consultative meetings involving key public health leaders, policy makers, and those who prepare the national budget. They provide a template for budget club members to fill in information regarding budgets received locally; facility personnel (number of posts and vacancies, available housing, daily attendance, etc.); maintenance of vehicles, furniture, and equipment; availability of drugs; food quality; cleanliness; ward maintenance; EPI outreach center service delivery; and satellite clinic service delivery.

"I shared the idea with the budget club candidates. I told them about the challenges we had with health care and how they could use their voice and social acceptance to solve some of those problems through discussion. You can reduce poverty in your area. There will be less financial loss. Think about it. People are not getting proper healthcare services at the union level, but if you request them, then maybe they will improve their services. There are other areas where the supply is less than the demand of that service, or that the budget is not adequate for the size of the population. If you address these issues and turn it into a social movement, then you can contribute more to the welfare of the society. This is how I approached the potential members of the budget club, and then I shared the necessary information and tools that were given to me and they were convinced that they could indeed use that platform to do social good."

Member of local CSO that facilitated establishment of a budget club

BUDGET CLUB ACTIVITIES

Each month, members of budget clubs go to their Upazila Health and Family Planning Officer (UH&FPO) to ask if the month's installment of the budgeted funds for the upazila have arrived. Once the funds have been received, club members meet with the Head Accountant at the Upazila Health Complex and record the received amount in their data collection tool along with information on facility personnel (posts and vacancies, attendance, etc). DORP provides research support to determine the amount of funds allocated from the central level so the amount can be compared to that received at the local level. Budget club members then meet with facilities' storekeepers to record information regarding available medicines and with medical officers to complete the rest of the data collection tool and compare results against the Citizen's Charter. They also go to the union level and check if the month's satellite clinics and EPI programs were executed on the pre-determined date and time and if they were well attended. This routine data collection forms the evidence base for the budget clubs' advocacy activities.

Budget clubs convene monthly and discuss identified gaps and determine which unions are being most affected. They then meet with the appropriate Union Education, Health, and Family Planning Standing Committees during bi-monthly meetings to develop resolutions to address the problems. If solutions cannot be determined during these meetings, journalists are engaged to publish on the issues in newspapers. The next step in bringing light to issues is for budget club members to arrange meetings with the UFPO, UH&FPO, UNO and other managers for advice. These meetings are typically held every 3-6 months and have successfully resolved many issues identified by the monitoring activities. At the central level, DORP has discussed identified funding gaps with policy makers and Directors of Finance at the Directorate of Health and at the Directorate of Family Planning, and regularly presented recommendations at regional and national pre-budget meetings to inform the national budget formulation.

EXAMPLES OF IDENTIFIED GAPS

Lack of chairs in facility for waiting patients and for education sessions

Insufficient Drug and Dietary Kits received by union health centers

Communities without any access to health or family planning services

Lack of sign boards for health facilities

Lack of awareness in community about free medicines available at heath facilities

KEY ACTIVITIES

- Monitoring health and family planning budget received by upazila
- Monitoring of health and family planning service readiness and quality at local facilities
- Monthly budget club meetings
- Discussions on budget issues during bi-monthly Union Education, Health, and Family Planning Standing Committee meetings
- Advocacy meetings with upazila level government personnel concerning issues raised through monitoring
- Awareness raising in community through distribution of stickers, pamphlets, posters, TV shows, and public meetings
- Lobbying and advocacy efforts at central level

"We faced resistance at first, but we didn't lose hope and stayed persistent. We explored different ideas with the budget club on how to motivate people, what kind of information to share, how to build rapport with the Deputy Commissioner, Civil Surgeon, and others through social interaction. When we slowly started socializing with them, we also started discussing the issues with them and they slowly started listening. Then at one point, the UFPO said that the budget club was attacking him from all sides, but he didn't mind if that meant better healthcare in the upazila."

Member of local CSO that facilitated establishment of a budget club

In order to empower communities with information concerning their rights to quality services and to inform them of resources currently available and any discrepancies, budget clubs arrange miking, posters, sign boards, distribute stickers and pamphlets, host talk shows, attend village gatherings, and engage local imams. In this way, the budget monitoring process has been able to build bridges among communities, service providers, administrators, and policy makers to ensure the government's commitment to health is actualized and communities' needs are being adequately considered and addressed.

PROJECT COMPONENTS

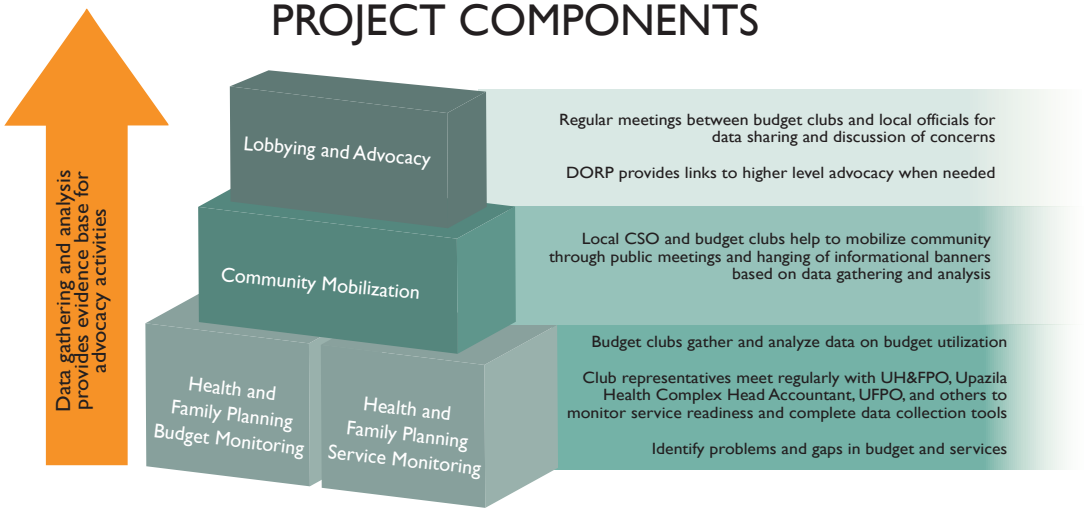


photo: Save the Children/Hasan Bipul

A budget club member collects data at a local health facility

CONTRIBUTIONS OF BUDGET CLUBS TO IMPROVED HEALTH AND FAMILY PLANNING SERVICES

DORP's own project documentation has highlighted the multifaceted benefits of the process and provided anecdotal examples of improvements in health and family planning services:

» **Improved budget allocation, disbursement, and utilization according to community needs:**

- Essential Service Delivery (ESD) development budget utilization increased in areas where budget monitoring was active
- Food allocations per hospital bed increased from BDT 45 to BDT 75

» **Improved facility infrastructure and service provision:**

- Regular monitoring and discussion has increased the number of satellite clinics being conducted according to schedule in project areas
- In various upazilas, officials and the local population were unaware that there was budget available for tube well maintenance at facilities, since this line item, among others, is not disbursed automatically from the central to upazila level, instead requiring direct requests from a local official. Through the budget monitoring process, budget clubs became aware of the allocated yet undisbursed budget, and successfully advocated for the tube wells to be re-opened.
- Community members in Kamalnagar advocated for electricity supply to their Union Health and Family Welfare Centre during a pre-budget meeting with upazila health authorities, which resulted in the installation of wire and meter

"We took the Upazila Health and Family Planning Officer to visit the flood affected locations that lacked health services. After his visit, he too realized that the health services of those areas were of very poor quality. After he came back to the upazila, he decided in the meeting that he would set up monthly camps to provide services to those areas. We were able to run a few of these camps through our budget club."

Budget club member

"The government gives various health services for free. They supply medicines. The maternal health center provides treatment to mothers. But people would not receive this information. So, when medicines arrived to the health centers, we would open the boxes in front of the community leaders including UP members and their committees. We then raised awareness; let the upazila and community know that they would get free medicine if they came here. We requested for an MBBS doctor to prescribe medicines that we didn't have in stock. We had a rundown room at the upazila health complex that we were able to mobilize the Union Parishad to fix. There is widespread awareness about this center now."

Budget club member

"We know that the government has budget allocation for health care development of those [hard to reach] areas. But they didn't go or provide the services. But since we started advocating and lobbying, the TSO came to know that we are keeping track of these things and that alerted them, which improved the situation. So it is not that the government didn't know—they allocated resources in terms of funds and manpower to serve in those areas, but the resources were not being utilized."

Budget club member

» **Improved community mobilization, awareness, and empowerment concerning health and family planning services, financing, and management:**

- Union Education, Health, and Family Planning Standing Committees have been reactivated and are meeting regularly

- Local communities now have access to information and a platform for discussing health issues, while budget club members have learned that local authorities can be approached to provide support

"One of our biggest achievements is the success we had in the two most neglected and flood affected areas of Sirajganj. There used to be a center for providing health services, but it went under the river and since 2005 the people of those areas were not getting proper health services. The health department appointed staff to visit the area, but they wouldn't go. But then, due to our advocacy and lobbying, the officers started visiting the locations. We successfully set up two healthcare centers."

Budget club member

» **Strengthened public-private relationships for health and family planning:**

- Frequent meetings among health facility managers, representatives of budget clubs, and union standing committees have resulted in improved understanding between service providers and recipients; service providers have an opportunity to be open with the community about their budget availability and constraints of budget utilization, which has increased service recipients' trust in their local health care facilities

- The Directorates of Health Services and Family Planning have gained trust in the budget monitoring process, as they begin to see how the process is complimentary to their own work in improving budget utilization per the government's commitment

photo: Save the Children/Hasan Bipul

This facility had been without a signboard until the budget club advocated for and arranged the signage to make it more visible to community members

KEYS TO SUCCESS

Flexibility fosters group ownership of activities: DORP and their partnering CSOs resisted making the monitoring process too formulaic, which they insist inhibits the creativity and flexibility necessary for effective advocacy work. DORP provided daily newspapers, a TV, and table and chairs for budget clubs so members could meet informally and discuss budget issues in a relaxed and inviting environment. Putting members in charge to decide how to run their groups and refraining from making strict prescriptions (such as requiring a certain number of meetings) led to strong member ownership and empowerment, and required less resource input from DORP.

Budget monitoring tools: In the early years of implementing the budget monitoring process, DORP was often requested to provide explanations of their methodology to stakeholders, and faced challenges when unable to do so clearly. DORP therefore developed the health and family planning budget monitoring data collection tools through a consultative process, which helped to clarify the methodology and facilitated the replication of the process in new districts.

Identifying and leveraging the strengths of each team member: Budget club members explored their existing networks and leveraged connections in their own respective fields to achieve the club's goals. Working as volunteers with very minimal project funding, budget club members engaged key community members to join their cause, such as journalists who are known for extending their support for good causes rather than working only for payment.

RECOMMENDATIONS

1. The GoB and NGOs should invest in making union standing committees functional through stronger training and more thorough orientations about their job responsibilities. When members have better understanding of what the committees are for, will they be better able to leverage them to make significant changes in their communities.

2. This project's national level advocacy mainly targeted the issue of proper utilization of allocated budget lines; however through the process, it became apparent how insufficient the allocations are to run the health facilities. DORP recommends NGO advocacy addressing all phases in the budget cycle, since solutions require changes in policy and budgets at the national level.

3. While strengthening public-private partnerships within their communities, groups interested in using this model of budget monitoring should emphasize how the process is not a policing exercise. Rather, it provides opportunities to create openness and trust among service providers, government managers, and the community by highlighting the services available, determining whether the community is able to access them, and identifying any gaps or bottlenecks that could be addressed locally in order to support the health system in reaching its goals.

FURTHER EXPLORATION

DORP has begun supporting the application of bottom-up budget monitoring activities to WASH issues in selected communities and is seeing positive results. DORP has also provided workshops for NGOs interested in learning how to implement bottom-up budget monitoring activities in their own areas. The following list of programs could yield additional lessons learned and could be considered for similar documentation in the future:

- Strengthening Democratic Local Governance in Bangladesh Project (USAID)
- Horizontal Learning Program (World Bank)

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photo: Save the Children/GMB Akash

Establishing a Sustainable Cadre of Private Community-Based Skilled Birth Attendants (P-CSBAs)

CARE Bangladesh

Purpose: To create a sustainable skilled community health worker model to address gaps in government maternal and newborn health service provision in hard-to-reach areas of Bangladesh and thereby reduce maternal and neonatal mortality through improved access to antenatal care (ANC), safe delivery services, postnatal care (PNC), newborn care, and community-based integrated management of childhood illness (C-IMCI).

Approach: CARE Bangladesh, GlaxoSmithKline (GSK), and the Government of Bangladesh (GoB) have developed an innovative public-private partnership to support the development of private skilled health providers supported by communities, the public health system, and local government. Through a rigorous selection process, eligible women are identified from within their communities and provided government accredited training at district level nursing institutes facilitated by Obstetric & Gynecological Society of Bangladesh (OGSB) under the supervision of Bangladesh Nursing Council (BNC) to become private community-based skilled birth attendants (P-CSBAs).

Positive Changes: The percentage of births attended by skilled health staff in the project area increased from 11% (project baseline, 2013) to 48% in December 2014. Program monitoring data showed 32% of these births were attended by P-CSBAs. As a result of the program, community members are relying less on the services of unskilled traditional birth attendants; ANC, PNC, and community IMCI service utilization is increasing; and P-CSBAs are earning sustainable income.

photo: Save the Children/GMB Akash

P-CSBA Minara Akhter providing PNC to Habiba and her daughter Rabeya

BACKGROUND

P-CSBA Amena Akter in Chikorkandi, Sunamganj

As overall maternal, neonatal, and child health (MNCH) indicators continue to improve in Bangladesh, economic and geographical disparities in health access and outcomes persist, particularly in remote areas of the country. Poor retention of public sector skilled healthcare providers in hard-to-reach areas leaves many communities without access to safe delivery services and skilled care for newborns. To help close this gap, CARE Bangladesh, with the funding support of GlaxoSmithKline, has signed a memorandum of understanding (MOU) with the Ministry of Health and Family Welfare to support the establishment of a cadre of private community-based skilled birth attendants (P-CSBAs) in 50 unions under 10 upazilas of Sunamganj District. Although P-CSBAs are not government staff, they are endorsed by the government and are provided resources, supervision, monitoring, and support by the public health system.

Sunamganj is a *haor* region comprising many hard-to-reach areas. Findings from the program's baseline study conducted by International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) in 2013 revealed that MNCH indicators in Sunamganj District lagged far behind national averages. For instance, 87.6% of deliveries were conducted by traditional birth attendants or relatives—a percentage much higher than the national average of 67.4%.* Additionally, neonatal mortality was estimated at 42 per 1000 live births compared to 32 nationally.* Community members preferred home deliveries because of the unaffordable costs of MNCH services in facilities, lack of female doctors and adequate facilities in the government hospital, and inconvenient communication and transportation systems, among other reasons.

CARE Bangladesh strove to develop a long-term community health worker program (CARE-GSK CHW Initiative) inline with the government system to complement the public services already being delivered in order to ensure increased coverage of essential MNCH services in Sunamganj District. CARE Bangladesh aimed to ensure community ownership, adequate linkages with existing health services, high-quality basic training and regular refresher training, strong supervision, and an appropriate social entrepreneurship model so the program would be sustainable and could result in the development of a toolkit for scale-up after the project is formally evaluated.

* Comparative analysis of project's baseline findings in 2013 with Bangladesh Demographic Health Survey 2011

PROGRAM AIMS

1. Enhance community efforts to create local solutions that improve MNCH outcomes
2. Create sustainable health providers that can offer affordable and high quality MNCH
3. Enhance effectiveness of community-led accountability mechanisms
4. Leverage learning to improve MNCH health outcomes for remote communities in Bangladesh

P-CSBA SELECTION PROCESS

photo: Save the Children/GMB Akash

P-CSBA Amena Akter on her way to attend a delivery in Chikorkandi, Sunamganj

"This is a very hard-to-reach area. In order to get to the nearest service center, one has to use three different types of transport. First they take a boat, then a car and then a rickshaw. This is why many don't want to come. But since the P-CSBA goes to their doorstep, they don't have to travel far to receive services anymore. The villagers are really happy about that. They say that they feel comfortable knowing that the P-CSBA is one of their own. They are happy that they can reach her at any time during emergencies. The community and the society have accepted this program very positively."

Deputy Director Family Planning, Sunamganj District

A GoB-approved recruitment committee is responsible for managing the process of selecting candidates to be trained as P-CSBAs. This committee comprises program staff, local government officials, members of the community, and managers in the Ministry of Health and Family Planning. The committee ensures public announcement of the posts, and encourages teachers, religious leaders, local government, and community groups to recommend candidates. The committee then reviews applications, conducts interviews, shares expectations, visits the homes of candidates, and proctors a competitive exam before selecting the most appropriate candidates for training. Approximately one P-CSBA per ward is selected for training, resulting in the appointment of approximately 3 to 4 P-CSBAs in each union of the program area. The recruitment committee follows selection criteria prescribed by the Bangladesh Nursing Council (BNC), which requires candidates to be females between the ages of 25 and 40 who have at least a secondary school certificate (SSC), live in the community where they will serve, and are or have been married. Each candidate's family must be supportive of her appointment, and she must have a long-term commitment to serve the catchment populations after her training.

PROFESSIONAL TRAINING FOR P-CSBAs

During the period of needs assessment and design for the project, CARE Bangladesh recognized that providing long-term training covering a relatively large number of skills would be critical in enabling P-CSBAs to charge fees for their services and thus create a sustainable cadre of skilled providers in underserved areas. P-CSBAs undergo intensive 6-month competency-based training provided by the Obstetric and Gynaecological Society of Bangladesh at one of five GoB Nursing Institutes (Kishorganj, Brahmanbaria, Netrokona, Jamalpur, and Narsingdi) aimed at developing technical capacity and counseling skills associated with uncomplicated pregnancies in the community. Trainees receive classroom and clinical instruction before completing a period of community practice and hands-on training within public hospitals. CARE Bangladesh also partnered with JITA Social Business Bangladesh to provide basic business and entrepreneurship skills training to P-CSBAs to assist them in earning income from their services and selling health commodities in their communities.

Comprehensive Training

For 90% of the P-CSBA candidates, training marks the first time they have travelled outside their own rural village. For this reason, the first few days of training focus heavily on increasing P-CSBAs' confidence. Trainees then discuss topics such as gender discrimination, MNCH in Sunamganj, and primary healthcare before embarking on the 6-month intensive training in skilled delivery assistance.

Transparent Service Pricing

P-CSBAs' service price is fixed by their union through a consultative meeting with local government and existing government service providers.

Once a P-CSBA has completed her training, she is introduced back into her community through a musical drama performed by a well-known local folk music group. This event is an entertaining way to inform community members about the P-CSBA's skills and to encourage the community to support the P-CSBA and utilize her services. The musical drama also covers topics such as how to care for a pregnant woman, 5 danger signs of pregnancy, and nutritional needs of mothers and babies.

photo: Save the Children/GMB Akash

COMMUNITY ENGAGEMENT

To foster community engagement and the development of community-led accountability mechanisms in support of the P-CSBAs, CARE Bangladesh is implementing their well-documented community mobilization approach known as Community Support System (CmSS) in the program area. Field facilitators (program staff) work to reform the existing government-mandated community clinic support groups within the program area by providing additional training and support to transform them into functioning CmSS. These groups of proactive community members develop yearly action plans for MNCH improvement within their communities and chart progress during monthly courtyard meetings. They keep updated maps of their community with the names and locations of pregnant women, particularly noting risky cases and the extreme poor so they can ensure necessary support. Additionally, CmSS groups raise funds through their community and the Union Education, Health, and Family Planning Standing Committee of the Union Council in order to subsidize P-CSBAs' transport, pay P-CSBAs for their services when families are too poor to pay service fees, and to cover emergency medical costs incurred by community members.

photo: Save the Children/GMB Akash

A CmSS meeting

Expectations for CmSS

1. Service promotion for P-CSBA
2. Service pricing
3. Ensuring social security of P-CSBA
4. Identifying and removing barriers that P-CSBA faces
5. Generating emergency fund for P-CSBA
6. Establishment of transportation system
7. Resource mobilization to support P-CSBA activities (through Union Parishad)

photo: Save the Children/GMB Akash

Joli Akter, a CHW, works with her CmSS to update a map of pregnant women in their community

Each individual P-CSBA is supported by one CmSS group. CmSS members help to select the P-CSBA candidate within their community for training, so the P-CSBA is accountable to the CmSS and keeps them updated on her work. In return, the CmSS supports her, ensuring her safety and arranging transport when necessary to attend deliveries. If a P-CSBA faces any difficulties, she shares with the CmSS and the members take immediate action to decide who will address the concerns in the community.

In addition to the CmSS, the program has established a cadre of community health workers (CHWs) to complement the work of the P-CSBAs. Approximately 12 CHWs per one P-CSBA are appointed to receive a 5-day training covering selected topics in primary healthcare. CHWs identify pregnant women, encourage families to seek ANC and PNC, conduct birth planning sessions, and record births and maternal and neonatal deaths in their catchment area of approximately 150 families. These data are routinely shared with P-CSBAs and with the CmSS during their monthly meetings. CHWs also participate in quarterly meetings at the Union Parishad office to monitor their performance and address challenges.

photo: Save the Children/GMB Akash

CHW Joli Akter conducts a birth planning session with Khodeja and her husband Sahanur Alam in Chandi Bari, Sunamganj

PUBLIC SECTOR LINKAGES AND REFERRAL SYSTEM

Strong linkages with the public healthcare system are an important component of the program. To ensure the long-term sustainability of the P-CSBA model and continued monitoring through the public healthcare system, CARE Bangladesh supports GoB-approved trainings to public medical officers, nurses, midwives, and Family Welfare Visitors (FWVs) in Sunamganj. These care providers receive orientation on the roles the government has instructed P-CSBAs to perform, along with training-of-trainer modules (e.g. C-IMCI) to enhance their capacity to train P-CSBAs when they come to the public hospitals for refresher trainings. These government workers also receive orientation on how to support P-CSBAs during referrals and provide monitoring and supervision support. CARE Bangladesh has worked with the government to establish "skill labs" within government health facilities in each of the 10 upazilas covered by the program. These skill labs are used for monthly P-CSBA refresher trainings, led by program Field Trainers, focused on hands-on practice with dummies to improve technical skill and confidence. The aim is for the district health and family planning department to take over the skill labs at the close of CARE's program and use them not only for P-CSBA refreshers, but also for the training of government staff and other service providers.

"The government is providing for us an office without any rent at the Upazila Health Complex. They are visiting the field and providing all relevant materials like ANC cards, iron folate tablets, misoprostol tablets, etc. We are working for the improvement of the health system here in Sunamganj, so we are getting all support from them."
Project Manager, CARE-GSK CHW Initiative

photo: Save the Children/GMB Akash

Hosne Ara Begum, Field Trainer Midwife in a "Skill Lab"

photo: Save the Children/GMB Akash

The program also hosted a referral linkage workshop in each of the 10 program upazilas where local government officers, CmSS members, health and family planning staff, CHW representatives, Ministry of Health and Family Welfare officers, RMO, UH&FPO, doctors, NGO and private health providers, and the Upazila Chairman participated. Participants discussed case studies of maternal and neonatal deaths resulting from poor referral linkages; discussed services available at the community, upazila, and district levels; and developed plans for quick referrals. They identified the special roles that community members, CmSS, CHWs, P-CSBAs, government care providers, and local government officers play in successful referrals. CARE Bangladesh formally introduced their referral slips during these workshops and ensured support from government facility personnel in giving importance to those referred. If facilities do not take special care of women with referral slips, CmSS members discuss the matter with the Chairman of the union where the woman lives who then raises the issue at upazila-level meetings.

FACILITATING REFERRALS

- All pregnant women are provided with emergency phone numbers for P-CSBAs, hospitals, ambulances, doctors, CNG (autorickshaw) drivers, and boat drivers
- When a P-CSBA receives a call for delivery, she notifies the CmSS and local government so they may be ready to assist if a referral becomes necessary
- If a referral is necessary, the CmSS notifies the Union Chairman who phones the Civil Surgeon to notify him/her that a complicated case is on the way to the hospital
- CmSS assists in providing funds and organizing transport to facilitate the referral

SUPERVISION AND MONITORING OF P-CSBAs

Program staff and government Family Welfare Visitors (FWVs) provide joint supervisory support for P-CSBAs in the community. Field trainers (program staff) regularly observe the work of P-CSBAs, providing technical support and organizing monthly refresher trainings based on their observations. FWVs also visit P-CSBAs, sometimes making joint field visits with program staff to observe P-CSBAs' work. P-CSBAs call FWVs if they face technical problems. In this way, CARE Bangladesh is trying to ensure there is a permanent monitoring and support structure in place once the program funding ends.

The government has organized a monthly union-level joint performance review meeting at the Family Welfare Center where all NGOs and government staff members working in health and family planning convene. Health and family planning managers attend this meeting along with Health Assistants (HA), Family Welfare Assistants (FWA), FWVs, and P-CSBAs who compile a report on the number of pregnant women, births, and maternal and neonatal deaths they have enumerated in the community using a common reporting system. This joint reporting ensures all women are counted and avoids duplication. The meetings also serve as forums to address performance challenges of the P-CSBAs.

photo: Save the Children/GMB Akash

Contents of a P-CSBA's equipment bag

"We monitor the P-CSBAs to see if they are actually doing their job or just showing us on paper. Our health inspectors perform this duty. We basically oversee their work. If they ever face any problem, for example if there is a case of complicated delivery, then we help by providing them with nurses, medicines, and a vehicle and send them to the hospital for a safe delivery. We have helped quite a few cases like this."

Civil Surgeon of Sunamganj

"I have personally visited all the Union Parishads at the district level. I have introduced the workers from the department of family planning with the P-CSBAs and have asked them to cooperate with them at all times. They have been asked to prepare reports together, to make the delivery list together and discuss issues such as how many cases had complications, how many were referred to hospitals etc. This kind of work has to be done together. If they try to work alone, they won't be able to succeed. The government can also see that it benefits them, so we work well together. The group coordination is quite apparent here."

Deputy Director Family Planning, Sunamganj District

"You know that we have inadequate manpower. The health assistants have a lot to do; it becomes difficult for them to do their jobs. With the P-CSBA's help, we don't miss any mother, or pregnant woman. We have community health workers and volunteers in every union to assist the P-CSBAs. It gives us great satisfaction to be able to reach every mother."

Civil Surgeon of Sunamganj

CONTRIBUTIONS TO HEALTH AND LEARNING

Ongoing program performance monitoring data is revealing the initiative's contributions to improving remote communities' access to MNC health services, strengthening community engagement for health, and empowering women:

P-CSBA Minara Akhter providing PNC to Habiba

Nargis Begum with her newborn and P-CSBA Rehana Khatun

» **Increased uptake of skilled MNCH services**

- Births attended by skilled health staff increased from 11% (baseline study, 2013) to 48% as of December 2014; 32% of the births were attended by P-CSBAs
- Equity in service delivery increased; more than 68% of service recipients from P-CSBAs are either poor or extreme poor
- Project performance data show P-CSBAs contributing to increased skilled ANC and PNC utilization in 2014; 51.2% skilled ANC services and 59.3% skilled PNC services in the project area were provided by P-CSBAs

P-CSBA Rehana Khatun in her chamber located in the village market

"I was married off when I was studying for my SSC. I had my first child during my SSC exam. I later came to know that CARE was recruiting. I now perform between 5-10 deliveries every month. If the clients are well-to-do, then they pay 500 BDT. The poor can't pay and sometimes I even buy medicine for them with my own money. I have saved up from my income and have bought a piece of land."

Minara Khatun, P-CSBA

» **Empowerment of women in social entrepreneurship**

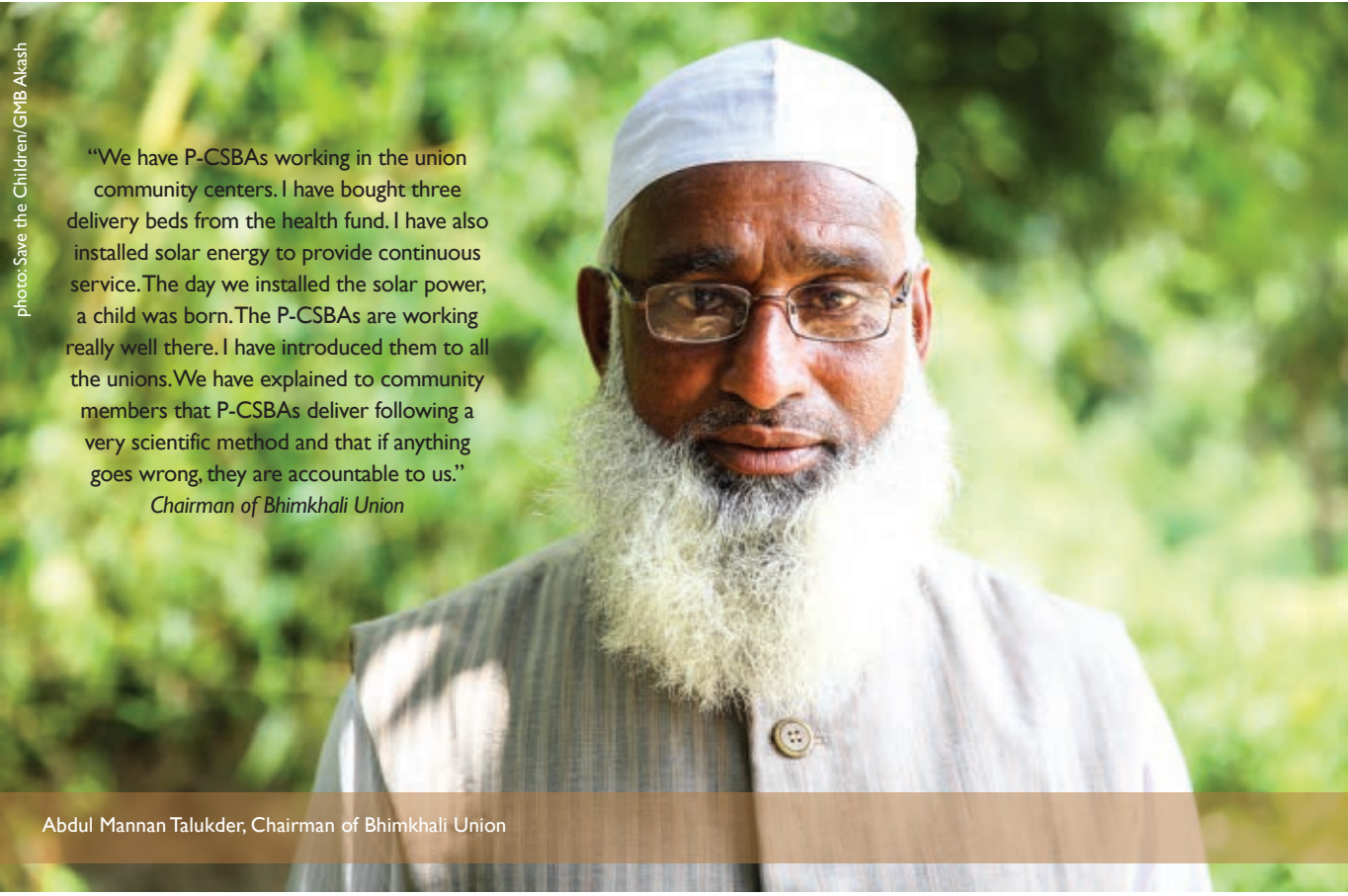
- Average monthly income of P-CSBAs is BDT 1,905; 33% of P-CSBAs earned more than BDT 3,000 and 15% earned more than BDT 5,000

- In addition to providing services in clients' homes, some P-CSBAs have supplemented their income by setting up chambers where they offer ANC and PNC services and sell health commodities (e.g. family planning products, medicines, nutritious foods, etc.)

» **Improved collection and use of data for decision-making**

- Data collected by CHWs and P-CSBAs are shared during monthly union-level joint performance review meetings to improve collaboration among government and NGOs; These data are analyzed and used for decision-making by the government

- CmSS groups use performance data to update community maps, ensure skilled pregnancy and delivery care through P-CSBAs, and provide effective referrals with monetary and transport support, especially for the poor



» **Active engagement of community in resource mobilization for MNCH**

- 50 local governments have allocated BDT 2,684,000 in their annual budget for MNCH activities
- BDT 440,550 was used to subsidize P-CSBAs' services for the poor, provide TBA orientation to reduce harmful practices, hold health camps for blood grouping, and to construct labor rooms, etc.
- CmSS have generated BDT 506,250 of their own funds and used BDT 87,607 for labor room construction, blood grouping, referral support, and observing health days (e.g. Safe Motherhood Day, Breastfeeding Week, etc.)

» **Consistent support and contributions of MOHFW**

- Provided office space for program staff in all 10 upazilas and Sunamganj District Hospital
- Provided 2.5 million iron and folic acid and misoprostol tablets for distributions
- Reimbursed fees for 445 skilled service to poor families under Demand-Side Financing (DSF) scheme in two upazilas

"I get a lot of support from Rehana apa [P-CSBA]; she comes to check on me every month. I asked Rehana to come for my delivery because I came to know she was an expert. My sister-in-law wanted to have her baby delivered by the village TBA, but the TBA didn't succeed and her urinary tract ruptured. The deliveries that Rehana apa performed have never had any of these complications because she has proper training."
Jharna, beneficiary

photo: Save the Children/GMB Akash

"The deliveries that are performed by the P-CSBAs are really good. The TBAs don't have the equipment that are important for saving the mother's and baby's life. The baby who was delivered the other day wouldn't have survived in the hands of a TBA and then we would have blamed it on some sort of demonic possession."
Golapi, CmSS member

photo: Save the Children/GMB Akash

KEYS TO SUCCESS

Extensive and continuous community mobilization for selection and promotion of P-CSBAs: Recruitment committees were faced with numerous cultural, religious, and educational barriers that made recruiting candidates for P-CSBA training difficult. To break down some of these barriers, comprehensive involvement of community members and relevant stakeholders was critical. The involvement of influential community stakeholders (e.g. teachers, religious leaders, local government officials, CmSS members) in the P-CSBA selection process was useful in that they were trusted within the community and could influence family decision makers. In addition, extensive community mobilization, house-to-house visits, expectation sharing, small village meetings, a transparent price-setting process, musical dramas, and the involvement of CmSS members, local government and health and family planning staff was crucial in providing continuous support to P-CSBAs once they completed their training and began working in their communities.

Strong communication with role clarification among multisectoral partners: Collaborating across NGO, private business, community, and government sectors is fraught with challenges, yet the program partners facilitated the process by signing formal MOUs and maintaining continuous dialogue from the inception of the program. Effective communication and relationship building was particularly critical when negotiating with traditional birth attendants (TBAs) and encouraging them to accept P-CSBAs into their community.

Encouragement of social entrepreneurship for sustainability: Enhancing social entrepreneurship skills has the potential to provide private service providers with financial sustainability after the project funding ends. P-CSBAs have strengthened their skills in business planning, developing diverse revenue streams, securing reliable sources for procuring medicines and supplies, and inventory management.

"We never hide or discourage TBAs, but we encourage them saying, 'You have been doing a good job for the community, now you have another qualified person here who has received technical training and a certificate and she is providing newborn care services in addition to safe delivery. When you will no longer be in the community, who will provide delivery services? You have a young, energetic service provider here and she is technically sound, certified by the government, and uses life-saving equipment...' Day by day TBAs become supportive and some jointly conduct deliveries with P-CSBAs. We recognize and honor them, and they become happy."

Project Manager, CARE-GSK CHW Initiative

RECOMMENDATIONS

1. A candidate for P-CSBA training, having at least a secondary school certificate, should be selected through an inclusive community consultation process from the community in which she will serve. Preferably, she should already be married, as this prevents attrition due to women moving outside their communities after getting married.

2. In such hard-to-reach areas, few women have the level of education required to be considered for P-CSBA training, and those few who are eligible may be unable to leave the district for 6 months of training. Therefore, P-CSBA training should be provided within the candidates' districts to reduce barriers to participation.

3. Continuous supervision, monitoring, and on-the-job training to improve and maintain P-CSBAs' skills and motivation are essential for better performance. Intermittent skill lab practice and technical supervision are key.

4. Strengthening referral linkages must be a primary objective of P-CSBA programs to limit instances where demand for EmOC services is created in the community but adequate service availability is not ensured at government facilities. Continuous dialogue and feedback among community, local government, and facilities can encourage better matching of supply and demand.

5. Active community engagement and participation is essential to establish a sustainable P-CSBA program. NGOs and others working in the local community should work closely with the government to ensure inclusion of proactive individuals, as well as provide additional support for thorough training and monitoring of existing community support group (CSG) activities. Strengthening the capacity of these support groups to develop problem trees and action plans and to monitor progress towards community MNCH goals should be a priority.

6. Participatory service pricing for P-CSBAs is essential to promote accountability, transparency, acceptability, and to address equity issues. Under the leadership of Union Parishad Chairman with the active participation of community representatives, MOHFW staff, and P-CSBAs, appropriate fees for P-CSBA services should be determined and broadly shared within the community.

FURTHER EXPLORATION

Other program models for private skilled birth attendants exist across Bangladesh. Although we have highlighted some lessons learned from just one example, we recommend further documentation of other models, which could yield additional insights into the keys for successful implementation and sustainability in comparison with the Government of Bangladesh's CSBA program:

- MaMoni Health Systems Strengthening Project (Save the Children)
- Safe Motherhood Promotion Project (JICA)
- Improving Maternal, Neonatal and Child Survival Program (BRAC)

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photo: Save the Children/GMB Akash

photo: Save the Children/GMB Akash

Institutionalizing Kangaroo Mother Care in Health Facilities

LAMB Integrated Rural Health and Development

Purpose: To reduce neonatal mortality by improving quality of care for low birth weight newborns and hypothermic normal weight babies.

Approach: Kangaroo mother care (KMC) has great potential to reduce neonatal deaths in Bangladesh where the rate of low birth weight is among the highest in the world. However, uptake of KMC in the country to date has been limited. LAMB Integrated Rural Health and Development was first to introduce KMC in Bangladesh in 1998, and has established itself as a strong in-country KMC training resource. As Bangladesh recently committed to accelerating the implementation of KMC in facilities across the country, LAMB can be highlighted as a successful model and source of important lessons learned.

Positive Change: LAMB has succeeded at enabling a strong KMC team culture within LAMB Hospital, where KMC is now part of routine care for low birth weight (LBW) babies. Mothers are empowered to provide care to their low birth weight, often preterm, babies and the hospital has seen a temporal relationship between improved neonatal survival before discharge and the time period of KMC institutionalization. Remarkable survival stories of very low birth weight neonates successfully cared for with KMC have inspired and sustained the motivation of health providers and families of small babies to encourage and support the practice.

LAMB Hospital nurse assists patient with Kangaroo Mother Care

Photo: Save the Children/GMB Akash

BACKGROUND

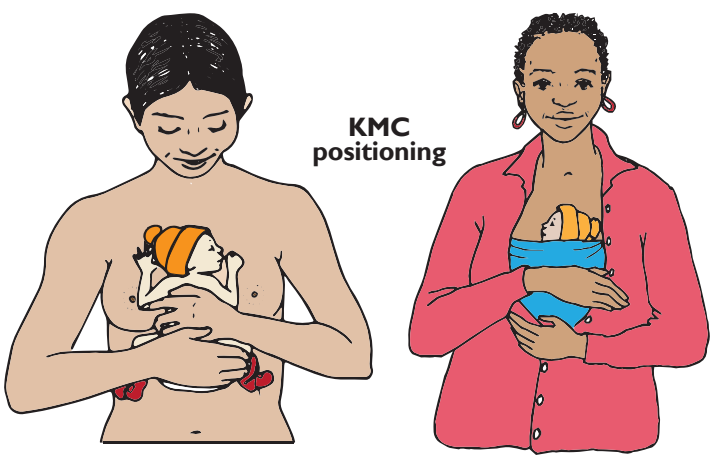
Kangaroo mother care (KMC), an evidence-based method of caring for low birth weight newborns, has been shown to prevent hypothermia and decrease neonatal mortality as compared to incubator care. Furthermore, KMC encourages mother-infant bonding, improves growth and weight gain, facilitates breastfeeding, and reduces the incidence of infections.[1] KMC comprises three key components: 1) continuous skin-to-skin contact between a neonate and his or her mother's bare chest, 2) early and frequent breastfeeding, and 3) early discharge from a health facility with follow-up.[2,3]

"I felt very well keeping my grandchild to my chest in skin-to-skin contact. It was a very good feeling. She never cried at my chest, I felt that she was getting comfort there. When she got hungry I gave her to her mother to feed."

Mother-in-law

Bangladesh has made remarkable progress over the past decade in reducing under-5 deaths, and indeed has already achieved Millennium Development Goal (MDG) 4. However, progress in reducing neonatal mortality has been slower, and now 61% of all under-5 deaths occur during the neonatal period.[4] Low birth weight may contribute to 60-80% of neonatal deaths globally,[5] and studies have estimated Bangladesh's low birth weight rate to be near 30%, which is among the highest in the world.[6] Low birth weight babies are at increased risk for developing hypothermia and infections,[7-10] and thus attention to thermal regulation of newborns in Bangladesh is critically important. It has been estimated that universal coverage of measures to prevent neonatal hypothermia in addition to quick identification and treatment could eliminate up to 40% of neonatal deaths globally.[11]

In renewed commitment to addressing neonatal mortality and acknowledging KMC's potential to save newborns' lives in Bangladesh, the National Core Committee on Neonatal Health endorsed KMC for national scale up in July 2013, and the Minister of Health and Family Welfare included KMC as a key intervention for scale up in his *Call to Action to End Preventable Child Deaths Before 2035*. As the Government of Bangladesh works to scale up KMC implementation in facilities nationally, it can draw lessons from the long history of KMC implementation at LAMB Integrated Rural Health and Development.



Figures adapted from Kangaroo Mother Care: a Practical Guide (WHO, 2003)

INTRODUCTION OF KMC AT LAMB HOSPITAL

LAMB Integrated Rural Health and Development is a faith based NGO working in Parbatipur, northwest Bangladesh. In 1998, two midwives from LAMB Hospital were introduced to KMC at the International Confederation of Midwives Conference in Manila, Philippines and returned to implement KMC initially for babies less than 2000 grams at LAMB Hospital. Although KMC has low financial cost and requires little technology to implement effectively, it proved harder than expected to sustain implementation. Initially, LAMB faced challenges from both the provider side and the patient side when trying to incorporate KMC into standard care in the hospital. The doctors were not open to changing their previous best practice of incubator care, nurses were overloaded and could not handle the additional workload of assisting mothers in initiating KMC, and new mothers and their families were resistant to the practice because of its unfamiliarity and often complained of feeling too hot. For the first several years, KMC implementation was unsteady, but the presence of a few "KMC champions" on staff continuously pushed for its institutionalization. These champions, comprising key pediatric doctors, strong nursing leadership, and nursing education consultants, worked together to innovate solutions to the challenges inhibiting the uptake of KMC at LAMB Hospital and, through their perseverance, have succeeded in nurturing a KMC team culture where KMC is now routine care for all small babies.

LAMB Hospital at a Glance

- Staff management under two directors: Medical Director and Nursing Director
- Approx. 22 doctors
- Approx. 100 nursing staff
- Approx. 17 medical assistants
- Approx. 200 total staff
- 150 beds
- 24/7 emergency care
- Patient fees charged at-cost; 66% of patients receive subsidies from a Poor Fund, 20% pay nothing
- 60,000 outpatients per year; 10,000 inpatients (50% pregnancy/birth related); 3700 births/year
- Catchment population of 1.5 million

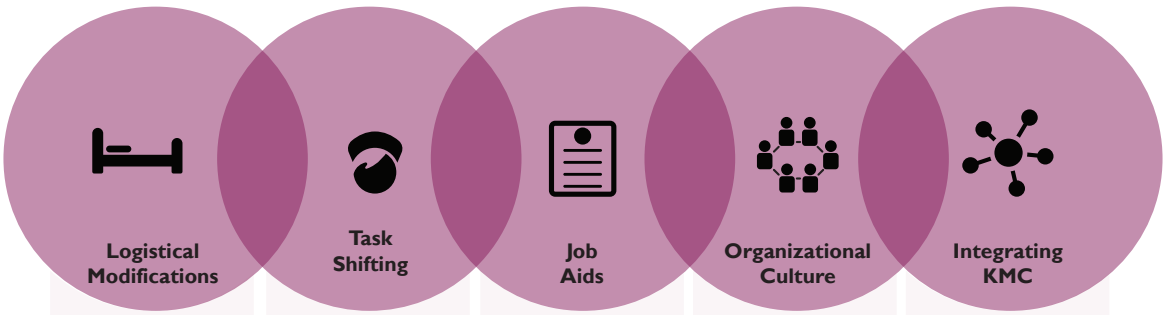
LAMB Integrated Rural Health and Development comprises:

- Community Health and Development Division
- 150 bed hospital
- Lamb Training Center (LTC)
- Nursing Institute
- Monitoring and Research Division
- English-medium school

photo: Save the Children/GMB Akash

INNOVATING TO OVERCOME CHALLENGES

The keys to LAMB's institutionalization of KMC comprise factors across five categories: logistical modifications, task shifting, job aids, organizational culture, and the integration of KMC across the facility.



Logistical Modifications

Restricted incubator use to only during phototherapy

Modified existing beds to allow backs to be raised and lowered

KMC bag and bucket system

Rearranged wards so nursing station is centrally located, next to patients

Task Shifting

Shifted task of counting number of births, cesarean sections, etc. from nurses to MIS-R team to allow nurses more time to interact with and directly support mothers

Job Aids

Streamlined patient recordkeeping by using structured clinical patient obstetric and neonatal sheets; Incorporated KMC prompts on all relevant patient records including ANC and PNC cards

Breastfeeding problem-solving flipchart and KMC survival stories used to educate and encourage mothers

Use dolls to demonstrate proper breastfeeding techniques

Organizational Culture

List of stated, board-approved values that guide the organizational culture and encourage accountability

Weekly maternity staff coordination meetings

Nursing staff highly valued

Strong leadership & presence of KMC "champions"

Respect for local culture, including modesty of mothers providing KMC

Integrating KMC

Having no separate "KMC Ward" creates the opportunity for observational learning among all mothers

Tools for supporting KMC available in every ward

Working towards "zero separation" between mother and baby after delivery

Doctors, medical assistants, and nurses all trained to provide and encourage KMC

LOGISTICAL MODIFICATIONS

Restriction on incubators

During the early days of KMC implementation, consensus was lacking among LAMB doctors on appropriate care for low birth weight babies, which caused confusion for nurses implementing the care. Some doctors prescribed the use of hot water bottles or room heaters while some insisted upon incubator use. Because of the scientific evidence showing the benefit of KMC over incubator care, a Consultant Pediatrician championing KMC ultimately managed to limit the incubators for use only during phototherapy treatment and KMC has become the sole method of thermal care for neonates.

Adapting hospital beds

In effort to increase comfort for women providing KMC, the hospital modified all their existing beds in the maternal, neonatal, and pediatric wards to allow the backs to be raised and lowered. This allows women to sit upright or rest in a semi-reclined position with their babies in the kangaroo position. Purchase of new, high-technology adjustable beds or chairs was not necessary.

"When the doctors are united and giving a clear message about quality of care, then it is helpful for the nurses. When one consultant does it one way, another consultant does it another way, it's difficult for nurses. That's an important leadership point—that the unit has to decide what is our quality of care, then everyone is clear-- every doctor and every nurse so that you move in the same direction. Otherwise, the nurses hear one thing one day and another thing another day."

Consultant Pediatrician

Nurse preparing a hospital bed that LAMB Hospital modified to allow the back to be adjusted

photo: Save the Children/GMB Akash

photo: Save the Children/GMB Akash

A Training Officer demonstrates use of the KMC bag at the LAMB Training Center

KMC bag and bucket system

During the first few years of implementation, nurses helped mothers to use triangular bandages or strips of fabric to secure their babies in the kangaroo position. By 2002, nurses were routinely encouraging mothers to use their own cloths like *orna*, *gamcha* or *lungi* brought from home. Then in 2006, LAMB designed and piloted a "bag" specifically for KMC, based on a photo seen in a KMC presentation from India. LAMB's early KMC bag prototypes were made with thicker, soft fabrics like flannel (brushed cotton), which ultimately proved too hot for use in Bangladesh and did not dry quickly enough after washing. Providing multiple sizes proved to be too logistically challenging, and thus the finalized version in use today is one standard size, made of cotton poplin fabric. Mothers' and their attendants' acceptance of KMC increased substantially after the introduction of the KMC bags, thus LAMB Hospital lends unlimited bags to admitted patients who then purchase 4 bags for home use upon discharge from the hospital. In 2012, LAMB began providing tailoring training to their cured obstetric fistula patients who now produce the KMC bags and knit baby hats and sell them back to LAMB Hospital as part of their income generation rehabilitation.

In 2009, LAMB instituted the "KMC bag bucket system" to facilitate access to clean KMC bags for admitted patients. There are two buckets in every ward in the hospital: a blue bucket of clean KMC bags next to a red bucket for soiled KMC bags. Mothers and their attendants are free to exchange soiled KMC bags for clean ones as often as needed, and the hospital's cleaning department is responsible for washing the KMC bags. This system prevents arguments arising over KMC bags that might occur if patients washed and dried their own bags on the hospital premises.

photo: Save the Children/GMB Akash

Rearranging ward layout

As in most hospitals in Bangladesh, LAMB Hospital was originally designed with an enclosed nursing station located adjacent to the maternity and neonatal wards. Hospital leadership recognized that after nurses completed job related tasks on the wards they had a tendency to retire to the nursing station room—from which patients could not easily be observed. In order to increase efficiency, LAMB relocated the nursing station to the center of the ward so nurses can easily observe and quickly help patients.

TASK SHIFTING AND REDUCING WORKLOAD

Overburdened nurses is a key constraint in institutionalizing a culture supportive of KMC in health facilities. In the early days of KMC implementation at LAMB, nurses were so overworked that they did not have the time, patience, and emotional energy necessary to provide proper counseling and support to women practicing KMC. In recognition of the importance of frequent interactions between nurses and mothers and continual encouragement to sustain KMC practice, LAMB shifted the tasks of counting patients, births, and number of operations to the Management Information Systems-Research (MIS-R) Department and also decreased the frequency of vital signs monitoring for stabilized patients, thus reducing nurses' workloads. LAMB began to see less burnout and "compassion fatigue" of nurses and the increased hands-on interactions between care providers and mothers resulted in expanded KMC provision.

"KMC is a nursing skill. If you don't have good nurses, you can't do good KMC. They are critical."
Consultant Pediatrician

MIS-R Assistant entering patient data in the MIS-R Department

photo: Save the Children/GMB Akash

JOB AIDS

Improving recordkeeping through structured clinical sheets and KMC-friendly forms

To further reduce unnecessary workload of care providers, hospital leadership introduced structured clinical patient obstetric and neonatal sheets ("circle sheets") in 2005, which reduced duplication and improved efficiency. These structured formats are used for admission history and examination sheets, delivery narratives, neonatal daily progress ward round sheets, and discharge diagnosis sheets, among other records. Rather than writing narratives in prose, providers circle a response from among pre-printed options on the structured sheet. A dark vertical line divides the sheet in two. When a provider circles an answer to the left of the line, the finding is normal or near normal, while circles to the right of the line indicate clinical abnormalities. Answers circled at the far right of the page indicate the most serious findings clinically.

As these sheets were updated, spaces for KMC-related reporting were specifically incorporated to serve as regular prompts for care providers to recommend KMC, provide KMC education and counseling to mothers during rounds, and regularly monitor KMC provision. Information and illustrations about KMC are also included on patient-held antenatal and postnatal cards, so all women receiving this care are exposed to the practice before giving birth and during follow-up visits after delivery.

BENEFITS OF STRUCTURED CLINICAL SHEETS

» Improved quality of recordkeeping:
  - Clinical documentation is more detailed and complete

» Increased efficiency:
  - Circling is quicker than writing prose
  - Risk factors and serious findings easily identified to the right of the line
  - Senior doctors can quickly identify abnormal history or exam by looking for circles to the right of the line and confidently assume other information is normal, which improves team communication
  - Saved time can be spent communicating with patients

» Useful teaching aid:
  - Sheet prompts new doctors for relevant history at admission and during ward rounds, specific examination findings to search for, and key diagnoses at discharge

» Streamlined data entry:
  - Circled responses entered directly by MIS-R Department
  - No need for separate data entry sheets filled in by nurses or clinicians, thus time is saved
  - Increases the amount of detailed data available for entry

photo: Save the Children/GMB Akash

LAMB Hospital nurse deomonstrates the "transitional hold" to a patient to facilitate breastfeeding

Improving breastfeeding

Babies are exclusively breastfed at LAMB; infant formula is not made available. For years, care providers at LAMB struggled to help mothers and their babies establish breastfeeding quickly in such a busy and resource-limited setting. LAMB found that introducing mothers to the "transitional hold" (also known as the cross cradle hold) revolutionized breastfeeding at the hospital, as the position significantly improved attachment. Improved breastfeeding increased mothers' confidence overall, and KMC uptake by mothers accelerated. LAMB now routinely uses an illustrated breastfeeding flipchart and neonatal sized dolls to model the transitional hold while counseling mothers and their attendants on breastfeeding techniques. The flipchart helps mothers prevent breastfeeding problems and find solutions if they arise.

Sharing of a KMC success story

Care providers also share photos of a KMC success story with all mothers of low birth weight babies and with the women's attendants. The photographs illustrate the story of a very low birth weight baby who survived because of her mother's provision of continuous KMC with good family support. This baby's survival marked another turning point for KMC implementation at LAMB, as individual doctors and nurses became fully convinced of the practice's benefit and renewed their commitment to ensuring all small babies receive quality KMC. New mothers of low birth weight babies and their attendants can relate to the story and photographs, and the care providers have found it a useful tool for counseling.

ORGANIZATIONAL CULTURE

Under strong hospital leadership who champion KMC, LAMB has overcome numerous challenges to succeed in creating a team culture that enables broad KMC provision. Nursing staff are highly valued at LAMB, which hospital leadership says is critical for the practice's success. In order to foster a sense of trust and mutual respect, and to give staff of all levels a voice, maternity staff come together once a week at 8:00 am and share tea together. These weekly meetings serve to improve accountability horizontally (as Medical and Nursing Directors do not attend), and provide an open forum in which nurse ward managers, senior doctors in obstetrics and pediatrics, medical assistants, health teachers, and chaplaincy can brainstorm solutions to current challenges and share encouragements such as updates on sick babies who have begun thriving in KMC. A Consultant Pediatrician also credits the fact that LAMB operates according to stated, board-approved organizational and staff values that encourage accountability as contributing to a positive facility culture that values staff of every level and cadre.

LAMB'S STAFF VALUES

- Compassionate and caring
- Honesty and integrity
- Teamwork
- Equal respect for all people
- Committed to quality

photo: Save the Children/GMB Akash

LAMB staff engage in weekly coordination meeting

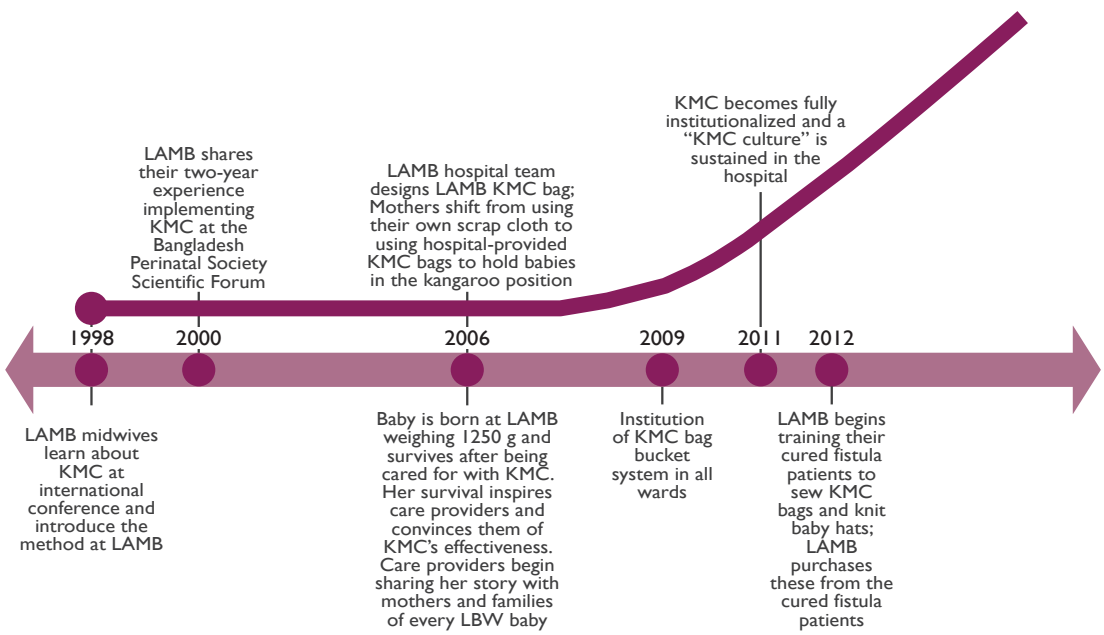
INTEGRATING KMC ACROSS THE FACILITY

LAMB has seen success in KMC implementation because of their integrated approach to encourage universal practice. Having no separate KMC ward allows the practice to catch on naturally throughout the wards as new mothers observe other women providing KMC in their beds. Furthermore, all care providers in the hospital receive orientation and training on KMC and encourage women to practice the care, including doctors, medical assistants, and nurses, so the responsibility of implementation does not fall solely on one cadre of care provider. LAMB Hospital did not receive project funding to implement KMC, rather the work has succeeded due to the motivation and creativity of visionaries on staff who have tirelessly encouraged strong communication among care providers, innovation, and perseverance amidst challenges in order to ensure the highest quality care for babies born at LAMB.

"We always respect the mothers' privacy during the practice of KMC. Being a male doctor, I never take the baby away from the mother's chest or touch the baby while it is being kept on the mother's chest in order to conduct an examination. I always prefer to take help from the nurses or other female staff before initiating the examination."

Male Pediatrician

PROGRESS TOWARDS KMC INSTITUTIONALIZATION AT LAMB



A GUIDE TO KANGAROO MOTHER CARE PRACTICE AT LAMB

Inclusion and exclusion criteria	All babies under 2500 grams or any hypothermic baby of any size is prescribed KMC at LAMB Hospital. (Until 2012, it was 2000 grams.) As KMC is the only method of thermal care for babies at LAMB, they have no exclusion criteria. All babies, whether stable or unstable, are cared for in the kangaroo position from birth. If required, babies are given oxygen through nasal cannula, IV dextrose, and occasionally continuous positive airways pressure (CPAP) while in the kangaroo position. KMC is also done during palliative care for dying babies.
KMC initiation and counseling	• ANC cards contain information and illustrations of KMC, so any woman receiving ANC from LAMB Community Health and Development or Hospital before delivery has been exposed to the practice • Inborn babies are weighed at birth and if determined to be LBW, the labor room midwife and nurses start KMC immediately and share KMC survivor photo story • When a LBW baby is born outside LAMB at home or another facility and brought to LAMB, the emergency room nurse educates the mother about KMC and helps her to initiate the care; this is reinforced by the medical assistant and doctors when they assess the baby • During the doctor's daily ward rounds, (s)he asks the mother if she has seen the KMC survivor photo story and knows the importance of providing KMC • During ward rounds, if mothers are not providing appropriate KMC, the doctors support the nurses in encouraging the mothers • A woman's attendant (family member) receives KMC education and counseling along with her • Babies born by cesarean section or babies of very sick mothers (e.g. eclampsia) needing KMC are transferred to the maternity ward where the family attendant gives skin-to-skin care until the mother can begin providing KMC herself
Duration of KMC provision	• Patients usually provide skin-to-skin care to their babies for 16-20 hours per day • KMC provision decreases during visitation hours (3:00-5:00 pm) because other family members want to see and hold their baby • Mothers are encouraged to provide KMC until their babies are no longer comfortable in the kangaroo position
KMC clothing	**Mothers**: Women are provided hospital gowns after cesarean sections, otherwise mothers wear their own garments in the wards. Maxi gowns with front zippers are conducive to KMC provision, as are saris with front closure blouses. Fans are employed during hot seasons to keep mothers more comfortable, and strict visitation hours means women can be sure of privacy during most of the day and thus feel freer to leave their clothing looser during the summer. **Babies**: LAMB ensures continuous supply of knitted hats and KMC bags while neonates and/or mothers are admitted. During the winter, babies often wear an open-front jacket and mothers drape blankets over themselves and the backs of their babies.
Feeding	All babies are breastfed or provided expressed breastmilk every two hours by their mothers with nursing support. Nasogastric tubes are used as required.
Sleeping	Beds are adjusted to allow mothers to semi-recline for sleeping while providing KMC. Attendants give skin-to-skin care to babies to allow mothers to fully recline and rest more comfortably when necessary.

Hygiene	In addition to the KMC buckets in the wards, there are two buckets under every patient bed: one for rubbish and one for dirty cloths. Mothers bring scraps of cloth (*nekra*) from home, which they place around their babies' bottoms inside the KMC bags. When a baby urinates or defecates, the soiled scrap of cloth is tossed into the bucket underneath the hospital bed and is later cleaned by the mother's attendant. The soiled KMC bag then goes into the red bucket labeled for soiled KMC bags in the ward, and the mother retrieves a clean KMC bag from the appropriate blue bucket. The scrap cloth together with the KMC bag acts as a nappy, keeping the excrement contained and limits soiling of the mother's own clothing.
Monitoring and recordkeeping	Ward nurses assess stable mothers and babies every 8 hours, including vital signs. KMC provision is recorded on neonatal daily ward round forms by doctors and medical assistants and on several postnatal assessment sheets by nurses. The forms include space to record every time health workers provide KMC counselling to mothers and their families.
Discharge criteria	• Mother is confident and proficient in providing KMC • Baby is breastfeeding or cup feeding well • Baby is growing • Small babies are sent home in the kangaroo position and 4 KMC bags are included in the hospital bill for home use (BDT 50 each)
Post discharge follow-up	Upon discharge, mothers are encouraged to return for scheduled PNC. KMC is illustrated on PNC cards and monitored during follow-up visits. However, PNC is not highly valued culturally, and mothers often do not want to return to the hospital. If the family is from a LAMB Community Health & Development area, PNC is provided in the home by Community Health Care Workers.
KMC in Community Health and Development Division	LAMB Integrated Rural Health and Development started as community work in the 1970s with satellite clinics that later became permanent health care clinics and Safe Delivery Units. For example, Ramnathpur mobile clinic started in 1997, in 2001 became a Safe Delivery Unit, and in 2010 was registered with the government as a community based organization (CBO) known as "Ramnathpur Samaj Unniyon Foundation." The unit is staffed by 3 skilled birth attendant-community paramedics (SBA-CP) with 6 community health workers (CHWs), one *ayah*, and one night guard. In 2013, LAMB began training their SBA-CPs and CHWs to implement KMC at the community level for families that declined to go to a facility for care of their LBW babies. In Ramnathpur alone, 34 LBW babies received KMC in the first year; KMC was initiated in the safe delivery unit for 15 of these babies, and the rest were born at home and received skin-to-skin care due to CHW outreach. Thirty-one of these babies survived.
KMC training for providers	• All joining staff are orientated on KMC from the beginning of their employment • LAMB Training Center (LTC) runs a 3-day KMC course using a bilingual manual (English-Bengali) that is offered to interested groups • LTC has provided KMC orientation and training to staff of other organizations, including icddr,b Matlab Hospital, Dhaka Shishu Hospital, and Save the Children • KMC training is integrated into all LTC courses for obstetric and neonatal care

photo © Save the Children/GMB Akash

KEYS TO SUCCESS

Effective communication among staff: The leadership at LAMB values effective communication among all cadres of care providers within the hospital, and thus provides a weekly forum for discussion in the absence of senior management. This provides opportunities for more horizontal accountability mechanisms, while also encouraging teamwork and improving trust among staff. While this forum is useful for discussing challenges and problem shooting, it also provides a forum for sharing encouragements over a cup of tea together.

Proactive leadership: Visionary leaders within LAMB staff persevered through numerous challenges that arose over the many years it took to institutionalize the practice of KMC within the facility. These KMC champions were proactive in innovating low-cost solutions and tools to facilitate KMC practice by leveraging existing resources without necessitating any designated KMC program funding. Most importantly, they continually promoted a shared vision among all staff of a facility where KMC would become the standard method of caring for all small and hypothermic babies because of its significant benefits for mothers and neonates.

Value and respect given to nursing staff: Nurses play a critical role in counseling and supporting mothers to provide KMC, thus good nursing is necessary for successful KMC implementation within facilities. Positive, respectful, and supportive working relationships among doctors and nurses are key to ensuring high quality health care and that mothers receive consistent messaging on how to care for their small babies. LAMB exhibits an organizational culture that highly values the nursing profession. Nurses are not treated as healthcare providers who only carry out doctors' orders, rather doctors and nurses communicate regularly to share challenges and brain-storm solutions arising in the wards and collaborate to jointly facilitate universal KMC provision for small babies within the hospital.

RECOMMENDATIONS

1. The important role of nurses as lead professionals can be promoted in Bangladesh; Implementation of KMC will be greatly facilitated in instances where nurses are highly valued and respected and where doctors and nurses work collaboratively

2. Ensure that healthcare providers and families of new babies understand that KMC has been scientifically proven to be more beneficial than care in incubators and radiant warmers and is not a "second best" alternative for poor hospitals

3. Provision of lightweight simple KMC bags can facilitate KMC uptake within facilities, along with other simple and low-cost innovations such as the KMC bag bucket system and the modification of existing hospital beds

4. A health facility should work to create a multidisciplinary team culture supportive of KMC, including doctors, nurses, medical assistants, FWVs, etc; KMC "champions" from all sides are critical, and effective communication amongst all cadres is key

5. Encouraging KMC provision throughout a health facility rather than only in a separate KMC ward may increase the opportunities for observational learning to occur among all new mothers and their families

FURTHER EXPLORATION

As the Government of Bangladesh has called for the acceleration of KMC implementation across the country, other hospitals are now learning from LAMB's vast experience and are working to encourage the practice in their own facilities. Further documentation of lessons learned from Dhaka Shishu Hospital as they begin KMC implementation, and from icddr,b Matlab Hospital as they transition out of project-funded implementation of KMC into integration of the practice across wards could yield additional recommendations useful for the scale-up of the practice. Furthermore, valuable lessons can be taken from a previous unsuccessful attempt to implement community-based KMC in Bangladesh.[12,13]

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photo: Save the Children/GMB Akash

LOCAL INITIATIVES TO IMPROVE SERVICE QUALITY IN A DISTRICT HOSPITAL

Jhenaidah Sadar Hospital

Purpose: Limited human resources and infrastructure are main constraints to effective health service provision at Jhenaidah Sadar Hospital where, like many district hospitals in Bangladesh, a large gap exists between hospital capacity and the community's demand for health services. In such resource-constrained settings, proactive approaches and strong community engagement are necessary for improving service quality and ensuring adequate and equitable access to services, particularly related to maternal and newborn health.

Approach: Proactive leaders within Jhenaidah Sadar Hospital ensured optimum use of existing resources provided by the government by fully engaging the hospital staff and further enlisted the active support of the community, local government, district administration, NGOs, and development partners to mobilize additional funding and human resources to meet the facility's needs.

Positive Change: Jhenaidah Sadar Hospital has seen significant improvements in performance and service quality within a few years. The community is satisfied and supportive of the facility, revenue has increased, the campus is clean and secure, and the 100-bedded hospital performed the highest number of normal vaginal deliveries in Khulna Division in 2014--more so than 250-bedded hospitals.

Jhenaidah Sadar Hospital

photo: Save the Children/Md Akash

BACKGROUND

Jhenaidah District in southwest Bangladesh has a population of nearly 1.8 million. Jhenaidah Sadar Hospital, the 100-bedded district hospital, is the main center for comprehensive emergency obstetric care (EmOC) in the district. The demand for services at the facility is much greater than can be met by current allocated resources; for instance, while equipped to perform 500 deliveries per year, the maternity department routinely performs over 2500. Thirty to forty mothers are admitted everyday, yet there are only 5 EmOC beds allocated by the government. By 2014, the hospital's occupancy rate had reached 180%. Even as demand for services increased over many years, there remained only one post for a consultant in obstetrics and gynecology, and one in anesthesiology, but no posts for medical officers in either department.

In March 2011, the Bangladesh Public Administration Training Center (BPATC) began providing technical assistance to Jhenaidah Sadar Hospital to implement a "5S-CQI-TQM" program for quality improvement within the hospital. However, after the first year of encouraging the process, few improvements had been made. With a change in hospital authority in May 2012, the program took off under new leadership. Taking a proactive approach to reforming the hospital service system through local initiatives and enlisting the aid of a strong community support system to provide additional human resources and infrastructure upgrades, the hospital saw tremendous improvements by 2013. The hospital is now among the best performing district hospitals in Khulna Division, having the highest number of normal vaginal deliveries (NVD) and the second highest number of total deliveries in 2014.

WHAT IS 5S-CQI-TQM?

3-step quality improvement tool useful in resource-constrained settings; supported in Bangladesh by the Japan International Cooperation Agency (JICA) and DGHS

"5S" refers to five components of work environment improvement that lead to improved staff satisfaction: Sort, Set, Shine, Standardize, and Sustain

"CQI" (continuous quality improvement) refers to a participatory problem solving approach by hospital staff

"TQM" refers to the Total Quality Management program of the Hospital Section under Directorate General of Health Services (DGHS)

Storeroom neatly organized according to the "5S-Continuous Quality Improvement" method

photo: Save the Children/GMB Akash

PROACTIVE LEADERSHIP IN ADDRESSING CHALLENGES

Upon being posted as Senior Consultant in Obstetrics and Gynecology at Jhenaidah Sadar Hospital in May 2012, Dr. Md. Emdadul Haque recognized that the environment was not conducive to providing quality healthcare services. Beyond constraints in human resources, the facility was dilapidated, stench filled the wards, staff were harassed at night by miscreants on campus, and cows grazed on the grounds among patients. He realized that the hospital would not gain importance in the community unless it was more inviting to staff and patients. With the vision of turning Jhenaidah Sadar Hospital into a model district hospital, the Senior Consultant took action steps to mobilize local support.

"You have to have good intentions, vision, good planning, and concrete action steps. Whatever I want to do it has to be clear and everyone needs to be motivated. It is quite possible to succeed in our efforts no matter how small or big the extent of the work is, if we follow these principles."

Civil Surgeon, Jhenaidah

Using data for decision-making

Acknowledging the importance of quality data to direct planning and decision-making, Dr. Emdad conducted a facility survey immediately upon his appointment in 2012, which assessed the current state of services and resources at the hospital. He then compared the data to those he had collected on his own initiative in 1998 while posted for 6 months as a medical officer in Jhenaidah. Hospital authorities used these analyses to identify problem areas and to develop an action plan for improvement. He also instituted improved recordkeeping practices within the obstetric ward such as introducing ANC cards, admission forms and register, and discharge forms. With a new emphasis on ANC services and increased capability in recordkeeping, the ward began producing monthly reports that were able to demonstrate an eight-fold increase in ANC visits from 2011 to 2014.

Obstetric Services at Jhenaidah Sadar Hospital (2011-2014)

Year	ANC Service	Admitted Patients	Type of Delivery			PNC
			NVD	CS	Total	
2011	1354	3906	1912	430	2375	2140
2012	2268	4261	1828	551	2379	2467
2013	7096	5445	1811	985	2796	3806
2014	10811	6095	1945	941	2886	3729

Dr. Emdad at a health education session in the hospital

Photo: Save the Children/GMB Akash

Setting an example through positive action

Believing that small incremental improvements lead to larger development as people witness change and become motivated to participate, Dr. Emdad began in his own obstetric ward—setting it as a model that could be replicated across the facility once the community and other doctors were convinced of the process. He equipped the obstetric ward with a telephone and began funding the call credit to facilitate communication among staff during obstetric emergencies. He also enlisted the support of the Civil Surgeon to repair and repaint discarded hospital beds to increase the ward's capacity, encouraged patients to bring their own rexine (coated, wipeable cloth) during deliveries so beds would not become soiled, instituted daily health education sessions, advocated for the construction of additional washrooms, and rearranged the pre-labor and labor room layouts for improved efficiency. The example of his tireless work ethic compelled other obstetric ward staff to go beyond their duty to ensure they were meeting the needs of their patients.

"There is too much workload on all of us. We are under a lot of pressure. Everyone used to say, "Sir we can't do this," but now everyone does it. If nobody would stay on, he would stay all by himself. Now if he can do his part, we can't just say no!"
Senior Staff Nurse

"I do not want to see these institutions depending on any one person. I would like to institutionalize the changes. Small developments such as having an emergency department, having a display of essential information, beautification—these are small steps but are much appreciated by the community."
Senior Consultant, Obs. & Gyn., Jehnaidah Sadar Hospital

"Some just take the easy way out and do not want to get involved in solving any problems. And then some see challenges as opportunities and want to overcome them. He accepted the challenge and convinced others to perceive this as an opportunity. If people trust you, they will extend support to whatever you do and that is the main driving force. People can see that he is not self-centered. People see him do so much that they also feel motivated to do their part." *Deputy Commissioner, Jhenaidah*

Upon witnessing *ayas* accepting bribe money from patients, Dr. Emdad took immediate action to prohibit the practice. He vowed to manage funds to pay *ayas* a regular and legal salary to keep them from relying on bribes. When he began paying out of his own pocket, other doctors, local government officers, administration, and socially conscious community members were motivated and came forward to donate regularly.

"The strength of the leaders here are that they are honest people. If you are honest then you will have courage, and you can do any kind of work. People respect and value an honest person and fear to do anything against them. If Dr. Emdad conducted c-sections in a private clinic outside of the government hospital, then patients would think that he intentionally refers mothers to a private clinic. But he is doing the opposite. He encourages the private clinic patients to come to the Sadar Hospital. He assures the patient better treatment without any cost." *Mayor, Jhenaidah Pouroshabha*

"Dr. Emdad works tirelessly. He has an assistant – Abdur Rahman, who is an anesthesiologist. He is also like Dr. Emdad. If he is summoned even at midnight, he won't hesitate. No matter what time a patient goes, be it during the day or 3:00 am, he is there with Dr. Emdad. When people know that there is someone like him in the hospital, then they won't wonder at 5 in the morning if the doctor is available and go to the private clinic instead." *Deputy Commissioner, Jhenaidah*

"Dr. Emdad is never cross with the patients. He never loses his temper and always addresses his patients as *Ma* ("Mother") during each delivery." *Senior Staff Nurse*

photo: Save the Children/GMB Akash

Community engagement

Members of local community organizations have been active in supporting Jhenaidah Sadar Hospital for several years. Upon Dr. Emdad's appointment, he sought out these interested individuals and worked to engage further support from local government authorities (e.g. Mayor), the local MP, district administrators (Deputy Commissioner, Social Welfare Officer, etc.), media, human rights organizations, social workers, cultural activists, businessmen, and local professors. Seizing every opportunity to meet with stakeholders and using facility data to inform them about pressing public health issues, community needs, and the constraints faced by the hospital, Dr. Emdad was able to motivate individuals to take shared ownership of the situation.

"You will never overcome by pursuing only power and authoritarianism. Counseling and motivating the people is the big thing here. Emdad bhai is able to convince people successfully in Jhenaidah, and he can do this because he has the mentality to serve the people. If he were a businessmen or a heartless person then it will not be possible. Our new Hospital Superintendent is also following this approach to motivating people."

Mayor, Jhenaidah Pouroshabha

"I was very surprised the doctor proactively met with us [at a Shilpakala Academy cultural event]. When we got off the stage, Dr. Emdad came and introduced himself. He mentioned that he was the area's Gyn consultant and invited us to visit the hospital. I wondered why he came there and met with us. We usually chase them, right? We started inquiring about him and found out what kind of a person he was."

Cultural activist and teacher

With Dr. Emdad's encouragement, the newly posted Civil Surgeon took the initiative to begin daily visits to the facility to check if ceiling fans and water supplies were working and trash was removed, the District Health Improvement Committee headed by the MP was reactivated, hospital staff began meeting regularly to discuss quality of care issues, and a local businessman responded to requests for support by donating an emergency generator to allow surgeries without power interruptions. Most importantly, funds have been mobilized from community sources to support small salaries for 51 non-government volunteers in the facility to fill human resource gaps (e.g. nurse assistants, guard, gardener, ward boys, trolly pushers, cleaners, *ayas*, etc.). Community leaders in Jhenaidah insist that there are people in every community across the country who want to similarly donate funds for the betterment of their society, but are inhibited due to poor trust that institutions will use the money honestly. In Jhenaidah, community-donated funds are deposited directly into the bank, limiting chances of mishandling by middlemen. Supporters regularly visit the hospital, observe tangible improvements resulting from their donations, and remain motivated to continue their support.

"The Mayor, community organizations, our doctors started donating. Then everyone came forward. They saw that their donations are not wasted. The hospital was clean. They all realized that this is our hospital. That is why they all contributed."

Civil Surgeon, Jhenaidah

Community-supported trolley men now work in the hospital

photo: Save the Children/CMNB Akash

A BIG CLEANING DAY

On 17th March 2015, the hospital celebrated its first "Big Cleaning Day," during which hospital staff and administration, local leaders, and government officials participated in a deep cleaning of the hospital and grounds. This event will continue to be held every third month.

photo: Jhenaidah Sadar Hospital

Mohammad Shafikul Islam, Deputy Commissioner

Dr. Reza Sekendar, Hospital Superintendent

Local leaders supportive of the hospital actively participated in cleaning the campus during the "Big Cleaning Day"

Saidul Karim Mintu, Mayor, Jhenaidah Pouroshabha

photos: Save the Children/GMB Akash

Dr. Mohammad Abdul Salam, Civil Surgeon, Jhenaidah

photo: Save the Children/GMB Akash

INNOVATING TO OVERCOME CHALLENGES

Hospital Information Center

Patients and their attendants struggled to get admission and service information quickly upon reaching Jhenaidah Sadar Hospital, which resulted in delays in receiving proper care. To address this, Dr. Emdad approached community leaders and requested them to expand their existing support. A wealthy businessman responded to the proposal, providing funds to build an Information Center at the entrance to the hospital in addition to supporting the salary of a non-government worker to serve patients in the Information Center. Patients can now have their questions answered quickly and be directed to the right places in the facility to meet their needs. Furthermore, patients' lab results can be collected at the Information Center during after-hours.

Cycle stand

Previously, bicycles and motorcycles were parked haphazardly around the hospital campus. With no security system in place, chaos would repeatedly erupt at the hospital when cycles were stolen. Hospital authority and a former Chairman of Jhenaidah Pouroshabha came forward to renovate a cycle stand on campus and outsource its management to a local community group. In addition to improving the hospital's environment, the stand has become a source of income generation. Earnings generated from the stand are used to support poor patients and the development of the hospital mosque.

photo: Save the Children/GMB Akash

photo: Save the Children/GMB Akash

Maintaining easily observable doctor roster and Citizens' Charter

Jhenaidah Sadar Hospital maintains a doctor roster in the corridor of the hospital so patients and their attendants can easily find information about doctors on duty for increased accountability. To further ensure patients have easy access to information, Dr. Emdad advocated for the renovation of a large painting of the Ministry of Health and Family Welfare's Citizen's Charter on the outside wall of the facility.

Intercom system for improved communication

To facilitate easier communication among hospital staff and thus improve efficiency of services, Dr. Emdad advocated for the installation of an intercom system throughout the facility. Having built such strong relationships within the community, his requests were quickly fulfilled by a local industrialist who donated the intercom system.

Directly enlisting support from development partners

Having witnessed the work of Japan International Cooperation Agency (JICA)'s Total Quality Management (TQM) activities under the Safe Motherhood Promotion Project Phase 2 (SMPP-2) in other facilities, Dr. Emdad took the initiative to motivate authorities at JICA and Directorate General Health Services (DGHS) to expand the reach of SMPP-2 to include Jhenaidah Sadar Hospital. In response, a JICA volunteer was posted at the hospital to facilitate Quality Improvement Teams and Work Improvement Teams and a learning visit was organized for a 15-member delegation from Jhenaidah Sadar Hospital to observe Satkhira District Hospital where SMPP-2 was active. This learning visit catalyzed attitude changes in hospital officers and staff and inspired them to promote improvements at Jhenaidah Sadar Hospital.

ACHIEVEMENTS AND POSITIVE CHANGE

» Active community participation
- MP, Mayor, local government, and community members including doctors of the hospital provide salaries for over 50 non-government hospital volunteer staff; contribute furniture and regular maintenance support
- District Health Improvement Committee reactivated

» Improved performance of obstetrics program
- Highest number of NVD and 2nd highest in total deliveries in Khulna Division
- Instituted ANC, PNC, and breastfeeding support services
- Provided privacy curtains
- Increased number of EmOC beds from 5 to 21
- Instituted shoe-free environment in operating room and improved infection control system

» Improved cleanliness and beautification of facility and campus
- Instituted waste management system and regular cleaning of drainage system
- Removed all unnecessary posters from walls
- Brought storerooms into order and neatly labeled all supplies
- Repaired campus boundary wall
- Created gardens for campus beautification

» Improved security
- Guards employed for 24/7 security

» Improved financial management
- Comparative data between August 2013 and August 2014 show an increase in total facility revenue from BDT 3.1 lakh to 5.5 lakh

"The biggest improvement is the environment. People are convinced they are in good hands. If we don't provide good services to the people, then our source of income will become uncertain, so the staff are convinced and willing to help. There seems to be a healthy competition to top each other's performance. If I am acknowledged as a hard worker and people are satisfied with my service, then that gives me self-contentment. We want to establish the hospital as a noble institution."

Deputy Commissioner, Jhenaidah

photo: Save the Children/GMB Akash

"The patients of Jhenaidah will make sure that this tradition continues in the absence of Dr. Emdad Sir. I firmly believe the public will make sure to keep it maintained what has been started. Even if doctors do not want to, the public will insist on it."

Senior Staff Nurse

KEYS TO SUCCESS

Holistic approach to health care: Dr. Emdad identifies as a public health specialist and development worker more than a clinician. He credits foundation training in development economics and public health as pivotal in shaping his philosophies and equipping him with the knowledge of how to select appropriate indicators for development and the importance of collecting quality data for use in strategy design. Emphasizing a holistic approach to health, he places importance on health education, preventative approaches to protect health, and networking with stakeholders across every sector.

Personal mastery: Dr. Emdad's integrity and strong work ethic has allowed him to lead by example and convince stakeholders to share in his vision for establishing a model district hospital. Rather than leading through exhibitions of power and authority, Dr. Emdad sees success because of his honest approach to information sharing and sincere concern for the community's needs.

Viewing challenges as opportunities: Fostering a positive work environment and seeing challenges as opportunities while taking small, incremental steps towards improvement rather than waiting only for increased government allocations led to a snowball effect in engaging staff and community. Observing incremental, tangible improvements at the facility builds the trust of hospital supporters (e.g. donors, volunteers, staff, and local officials), who then gain confidence to continue offering support.

Using data to motivate people for action: Dr. Emdad's successful partnership building for the hospital has been facilitated by his relentless sharing of facility data. Sharing concrete information about local health needs and the limited available resources with everyone from teachers, to government officials, and the media enables him to make a strong case for the need for strong community support of the hospital.

"I am working for the development of the whole country, not only as a gynecologist or a health worker, but as a development worker. When I speak to the community, I speak about holistic development. I link primary education, agriculture, and many other sectors to motivate them. Nutrition is linked to agriculture and without education, how can we prevent early marriage or encourage family planning?"

Senior Consultant (Obs & Gyn), Jhenaidah Sadar Hospital

photo: Save the Children/Shiraish

A community-supported cleaner sweeps the facility

RECOMMENDATIONS

1. Strong foundational training in public health, development, and strategic leadership can benefit all clinicians serving in the public healthcare system when offered early in their careers.

2. Provisions should be made to facilitate visits for hospital authorities and staff to observe model facilities and witness firsthand how strong leadership, community engagement, and innovation can result in sustained improvements in service provision quality. Facility tours and discussions with facility leaders, local officials, social workers, and volunteers could provide inspiration to health workers, and encourage them to transfer innovations to their own facilities.

3. The concept of volunteerism should be further fostered. Hospitals authorities should work to leverage support from interested community volunteers who benefit by gaining valuable hands-on experience in health service activities while contributing to the betterment of their community.

FURTHER EXPLORATION

Additional lessons in strong leadership and community-supported quality improvement of government health facilities may be learned from Dr. Emdad's well-known Chowgacha Model in Bangladesh. Beyond this, there are other initiatives that could provide beneficial insights, such as:

- Horizontal Learning Program (World Bank)
- Tangail District Hospital's experience with Total Quality Management

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ANNEX

The table below contains additional nominations that were included in the scoring phase of the documentation process.

TITLE	NOMINATING ORGANIZATION	KEY COMPONENTS & INNOVATIONS
Thematic Area: Increasing Skilled Birth Attendance/Promotion of Facility Delivery		
Community Safe Delivery Units (SDUs) staffed by community skilled birth attendants (CSBAs)	LAMB Integrated Rural Health and Development	• Uses appropriate level of care provider at community level facility at low cost • Sustainable as CSBAs are local, facilities simple but adequate, local communities have ownership and involvement • Low maternal and neonatal mortality; CSBAs make appropriate referrals • Promotes equity as women of all economic status have access to SDUs
Birth preparedness and complication readiness	Participatory Action for Rural Innovation (PARI)	• Birth and Emergency Preparedness Cards are distributed to pregnant women through CHWs and government service providers • Helps mobilize community for overcoming barriers to skilled birth attendance, such as transportation challenges • A simple, highly replicable intervention that is cost effective
Improving Maternal, Neonatal, and Child Survival Program: Supporting CSBAs	BRAC	• CHWs trained in basic community midwifery bridge the gap between demand and supply of skilled delivery care in rural areas • After being deployed in their community, CSBAs are accountable to community groups and are supported by technical supervisors and strong referral systems for EmOC
Increasing skilled attendance at birth by upgrading union level health facilities to provide 24/7 delivery services	Save the Children	• Upgraded union level government health facilities (UH&FWCs) in underserved unions of Habiganj district; ensured qualified paramedics (FWV, private paramedics) were present, and strengthened ANC outreach services of satellite clinics • Uses an operations research approach to ensure continuous learning and improvement of implementation
National CSBA training	GoB and WHO	• Trains existing government outreach workers (Family Welfare Assistants and Female Health Assistants) in a basic 6-month course to become CSBAs and provide home-based MNCH care
Thematic Area: Integration of MNCH-FP-N Services/Mainstreaming Nutrition		
Integration of postpartum family planning with maternity services: Mayer Hashi Project	EngenderHealth	• Focuses on expanding access and choice in contraceptive methods • Builds capacity among routine providers for long-acting and permanent methods of contraception
Health Fertility Study	Jhpiego	• Developed and tested an integrated FP/MNH service delivery approach in rural settings utilizing household visits by CHWs • Intervention activities include BCC on optimum pregnancy spacing and expansion of contraceptive method choices for postpartum women • The approach is sustainable and easily replicated in similar low-resource settings
Improving infant & young child feeding (IYCF) practices by introducing performance-based incentives to *Shasthya Sebika*	BRAC	• *Shasthya Shebika* (SS) are community health volunteers receiving a monthly financial incentive based on mothers' Infant and Young Child Feeding (IYCF) practices for their children 0-2 years of age • Performance-based incentive was introduced to provide financial assistance for ensuring the retention, success and empowerment of CHWs to improve IYCF practice

TITLE	NOMINATING ORGANIZATION	KEY COMPONENTS & INNOVATIONS
Thematic Area: Community Engagement		
Involving refugee population in providing MNCH-FP services among Myanmar refugees	Research, Training, and Management (RTM)	• Involved refugee workers and developed their skills in mobilizing communities, providing basic services, and referring clients to clinics • Aimed to create a strong group of volunteers from the refugee community to build awareness on health, hygiene, and nutrition in refugee camps
Thematic Area: Ensuring Equity in Service Delivery		
Satellite clinic operation at community level under Sheba Health Program	Bangladesh Extension Education Services (BEES)	• To improve access in underserved areas, trained paramedics operate satellite clinics at community level, under the supervision of professional doctors • Fills a gap in underserved areas while also strengthening referral systems • Paramedics conduct regular follow up with patients
Developing and training community paramedics	Research, Training, and Management (RTM)	• Advocated for GoB approval of community paramedics course • 13 institutions recruited trainees from selected hard-to-reach areas where skilled providers are not available
Integrated Community-Based Primary Health Care Model Program	Friendship	• Basic and essential needs are met by providing primary care through satellite clinics and static clinics while secondary and selective tertiary health care is provided through floating hospitals (ship/boat-based) • Fills the health services gap in extremely remote areas and has strong linkages with GoB for timely referral of complicated cases
Thematic Area: Adolescent Health		
Adolescent sexual reproductive health rights in disaster prone areas of Bangladesh	Plan International	• Established youth groups and trained adolescents to be peer educators to address sexual and reproductive health challenges encountered by adolescents during disaster situations • Stakeholders participated in "contingency planning" for adolescent needs during disasters
Thematic Area: Strengthening Provider Capacity/Quality Improvement		
Active Management of the Third Stage of Labor (AMSTL)	EngenderHealth	• Trained facility-based providers on AMSTL and advocated for improved oxytocin storage • Conducted a community-level pilot of misoprostol distribution for home deliveries
Cervical cancer see-and-treat	Friendship	• Facilitated the development of screening, diagnosis and treatment of cervical cancer prevention in two ship/boat-based hospitals • Friendship community medics are involved for outreach service and awareness program
Thematic Area: Male Participation in MNCH-FP-N		
Using satisfied No-Scalpel Vasectomy (NSV) recipients to work as referrers for NSV	EngenderHealth	• Engaged satisfied NSV clients as peer educators and promoters to increase demand for NSV • Engages men in family planning • Helps to overcome misconceptions about NSV

photo: Save the Children/GMB Akash