BREAKING THE MOLD

A Toolkit for the Replication of an Effective Urban Health Model

Based on a decade of urban health and child survival programming that has delivered effective, sustainable health care to one million of the poorest people across nine municipalities of Northern Bangladesh.

All photos: Bangladesh, Concern Worldwide

USAID FROM THE AMERICAN PEOPLE

CONCERN worldwide (U.S.) INC

Concern Worldwide is a non-governmental, international, humanitarian organization dedicated to the reduction of suffering and working towards the ultimate elimination of extreme poverty in the world's poorest countries. Since its foundation in 1968, Concern Worldwide has saved countless lives, relieved suffering and provided opportunities for a better standard of living for millions of people. Working primarily in the countries ranked in the bottom 40 of the United Nations Human Development Report, Concern implements emergency response programs as well as long-term development programs in the areas of livelihoods, health, HIV&AIDS, and education. For more information, visit: www.concernusa.org.

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FOREWORD FROM CONCERN WORLDWIDE CHIEF EXECUTIVE TOM ARNOLD

Tragically, in the time it takes to read *Breaking the Mold: A Toolkit for the Replication of an Effective Urban Health Model*, another 22,000 children will die from a common childhood illness. This is not just today, this week or this month—it's every day. And these deaths are preventable.

Concern Worldwide passionately believes that we must act now, and with a sense of collective urgency to focus global attention on this crisis and prevent further, unnecessary deaths. We know the killers: pneumonia, malaria, diarrhea, newborn infections and malnutrition—problems that have been all but eliminated in developed countries but which still devastate the poorest parts of the world. Proven, cost-effective interventions that safeguard the lives of children in the world's wealthiest countries often remain out of reach to millions of children each year.

Concern's Child Survival Program is our response. It's the latest chapter in the organization's more than forty-year history of innovation, practicality, and measurable impact, improving lives in the world's poorest and most vulnerable communities. With essential support from the United States Government, Concern's Child Survival Programs are proving that real, tangible progress is possible in Asia, Africa, and the Caribbean.

More than ten years ago, Concern made a bold decision to "break the mold" in Bangladesh by shifting our health model from providing direct service delivery to engaging local government and civil society in a cost-effective, community-driven urban health model. Working in partnership with United States Agency for International Development (USAID), Concern's innovative and effective Child Survival Program has grown from serving approximately 210,000 people in targeted communities in Bangladesh to **impacting the lives of more than three million people across Bangladesh, Burundi, Haiti, Niger and Rwanda**, including over one million women of childbearing age and 756,800 children who have received life-saving services.

The cornerstone of Concern's successful Child Survival model is its commitment to comprehensive programming, tackling social, political and economic issues that often hinder effective health service delivery. By scaling up community-based interventions, Concern has achieved significant results that are resolving the child survival crisis. Concern creates a collective focus on improving health systems in ways that are culturally sensitive, sustainable, affordable, and ultimately manageable by governments and communities. The resulting economies of scale and of scope eliminate the significant barriers that once kept these life-saving interventions out of reach. What's more, **Concern's global Child Survival Programs collectively cost a little over $2.75 per woman and child per year**.

And the impact of Concern's Child Survival Programs is profound: unprecedented reductions in child mortality; marked improvements in the quality and availability of local healthcare; measurable, sustainable increases in health indicators, not only at the mother-child level, but also at the community level; stronger health departments; better informed mothers and fathers; and safer community health practices.

Concern's Child Survival approach is the result of systemic, global vision, but its results are best viewed from the ground in the real stories of how partners come together to saves the lives of mothers and children. This Toolkit offers an "on-the-ground" view into Concern's Urban Health Model in Bangladesh. It was the first country of operation for Concern's Child Survival Program, and it's the most fully realized example of how the model works. What was once a pilot project targeting only a few communities has since activated lasting partnerships between communities, NGOs, the private sector and government, transforming health systems and ultimately saving thousands of lives. We hope that this Toolkit will provide guidance for other partners in the fight to prevent further, unnecessary deaths and to promote the health of the most vulnerable women and children.

Tom Arnold

ACKNOWLEDGMENTS

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Annexes on CD (affixed to back cover) are listed as follows:

A. Least Advantaged Group example criteria

B. Equity Analysis

C. Example of HICAP and Guidelines

D. Example Training Guidelines for members of the Community Volunteer Network

E. Sample BEHAVE Framework

F. Sustainability Assessment

G. Video: "Child Survival: Reaching the Poorest Women and Children in Bangladesh," Concern Worldwide, 2010

Available on Request

- Private Practitioner Training Facilitators Manual
- Health Information Management System Summary Data Collection form (in Bangla only)

Available on the USAID Development Experience Clearinghouse (http://dec.usaid.gov):

- Midterm and Final Evaluations

CHAPTER 1

INTRODUCTION TO THE URBAN HEALTH MODEL

PURPOSE OF THE TOOLKIT

Over the past decade, Concern Worldwide, Bangladesh (Concern) has implemented a cost-effective and sustainable urban health program in Northern Bangladesh with a focus on reducing child and maternal mortality and morbidity. Nearly 10 years ago, Concern made a bold strategic decision in Bangladesh. We shifted from directly providing care to communities to an approach that empowers communities to manage and implement their own health services. Our experience working in the world's poorest countries taught us that people living in extreme poverty are the most vulnerable to hunger and disease, and that existing health service and systems were failing to reach the poorest populations. We knew that improving the chances of survival for young children would require creative solutions. We also knew that long-term solutions require scale and needed to be cost effective. Concern's Urban Health Model has radically transformed how health is delivered in nine municipalities in Bangladesh - reaching one million of the poorest and saving the lives of thousands. Through committed partnerships to build capacity at the municipal level and mobilize the community at the grassroots, Concern and its partners facilitated a transformation in the health status of the extremely poor and vulnerable. The distillation of lessons learned has formed the basis of Concern's Urban Health Model, as described in this toolkit.

The purpose of this toolkit is to describe the components of Concern's Urban Health Model and explain how it was implemented. The toolkit includes the model's main elements, and a description of key inputs and processes such as community and human resources, capacity building activities, effective monitoring and evaluation systems, and partnership approaches. It even includes sample documents, such as capacity assessment tools, training outlines, a video documenting Concern's child survival experience in Bangladesh, and other key resources for implementers; making it possible for organizations to launch similar efforts amongst urban populations in Bangladesh and other countries facing similar challenges. Ultimately, the toolkit should provide guidance for others to strengthen urban health systems.

AUDIENCE FOR THE TOOLKIT

Urban health policy often falls into a gap between the Ministry of Health and the Ministry of Local Government. For example in Bangladesh, overlapping responsibilities between the Ministry of Health and Family Welfare and the Ministry of Local Government and Rural Development results in a lack of adequate human and financial resources devoted to urban health from either Ministry; translating into chronic understaffing, the absence of community health promotion, and a lack of coordination among government, private, and NGO service providers and donors in the municipal centers of Bangladesh.

Yet, despite the lack of ownership and coordination, the pressing health needs of urban centers must be addressed. This toolkit provides groups and organizations committed to improving the health situation in burgeoning urban areas, especially amongst the most needy populations, with detailed information explaining how Concern's Urban Health Model made a real and lasting difference. This community-based approach was effective at improving health indicators among maternal and child population and building capacities at the municipal and ward levels for improvements to be sustained.

For those working in Bangladesh, the Ministry of Local Government and Rural Development can utilize this toolkit as a basic guideline to provide municipalities concerned about the health status of their populations with an instructive model of how to move forward. Moreover, local NGOs working in urban areas can use the toolkit to strengthen ward-level health operations.

In addition, a number of donors (e.g., the Asian Development Bank and USAID) have invested considerable funds in urban health in Bangladesh and could benefit from learning about Concern's Urban Health Model.

While this toolkit is based on a Bangladesh example and lessons learned, it should be thought of as a set of guidelines on how to catalyze better health outcomes from under-resourced urban areas beyond Bangladesh. It

is possible to apply Concern's Urban Health Model, either in whole or in parts, to situations in other development settings, e.g., with rural health systems, since the basic principles of community organization, mobilization, empowerment and behavior change are still appropriate and some of the circumstances and challenges will be similar. Concern believes this model may also be adapted for strengthening rural health systems.

Therefore, this toolkit is intended for individuals, government actors, communities, civil society, and private health partners dedicated to improving maternal and child health.

CONTEXT

Rapid urbanization is a growing global health crisis with widespread health and development consequences. In fact, nearly half of the world's population resides in urban settlements, either formal or informal. Metropolitan areas and city centers host more infrastructure, providing greater economic and social opportunities, including employment, education, health care and culture. However, unplanned, rapid urbanization is associated with poverty, poor health, environmental degradation and astronomical population demands that deplete local resources, overwhelming service capacity and creating significant barriers to accessing services. As a result, rapid, unplanned urbanization compounds already harsh health conditions by increasing the risk of morbidity and mortality, especially among the poorest and most vulnerable.

Urbanization has become a significant problem in Bangladesh. The fastest-growing sector of Bangladesh's population lives in urban areas and a third of all people living in urban areas are living in slums. The urban population is expected to grow from 23 percent in 2001 to 33 percent of the total population (or approximately 50 million people) by the beginning of the second decade of the 21st century.

While many of the urban statistics indicate better access to and use of health services, there are large gaps between the highest and lowest economic classes. A quarter of the children residing in the metropolitan municipalities of Bangladesh live in absolute poverty, belonging to households that survive on less than $1.25 per day.[1] As the rate of urbanization increases, many of the aggregate figures continue to mask the reality for the urban poor. This population is highly vulnerable, faced with poverty, malnutrition, and poor health care services.

Municipalities are legally tasked with ensuring the delivery of primary health care services to the population, but have developed little capacity to do so. For instance, in 1995 the Ministry of Local Government, Rural Development and Cooperatives issued a circular[2] for the effective implementation of an Expanded Program for Immunization, along with primary health care services and family planning within municipalities through a coordinated mechanism involving Municipalities and City Corporations, the Ministry of Health & Family Welfare, NGOs, and private services providers. In theory, the circular formed committees at three different levels to ensure effective health service delivery:

1. An Inter-Ministerial Coordinating Committee at the national level
2. A Central Health Committee at City Corporation/Municipal level
3. Ward Health Committees at the community level

While this was a strategically sound approach, due to limited resources and manpower, public-sector health services were not able to meet the existing needs. On the flip side, private health care providers, which traditionally are the main source of curative care, especially tertiary and specialized services to urban populations, showed limited interest in providing the preventative and health promotion services the poor and vulnerable so desperately required.[3] With a disconnect between public and private healthcare spheres, Concern and its partners set out to build linkages and strengthen existing systems.

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[1] UNICEF 2009.

[2] Memo - Ministry Of Local Government, Rural Development and Cooperatives - Municipal-2/General-7/90/1392(350) Date: 28/11/95.

[3] See: Health, Nutrition, Population Sector Programme (HNPSP) - Revised Programme Implementation Plan (R-PIP) May 2005, MOH&FW, Government of Bangladesh.

HOW THE MODEL WAS DEVELOPED

In Rajshahi Division, where the Urban Health Model was developed, health services are delivered by a variety of public, NGO and private providers. The public health services include both outpatient and inpatient care, provided through district and medical college hospitals. In addition, antenatal care, delivery, postnatal care, comprehensive emergency obstetric care and family planning services are provided through district and medical college hospitals and maternal and child welfare centers.

In the private sector, there is a plethora of individual and group health providers, from qualified physicians to multiple informal "Private Practitioners," such as homeopaths, rural medical practitioners, and barefoot/untrained doctors. Yet, these health services are largely concentrated in urban centers, which reduced physical access for peri-urban residents. And, even more importantly, the quality of the providers combined with demand —which was not being met by public services — presented problems related to financial access, especially among the poorer segments of the population.
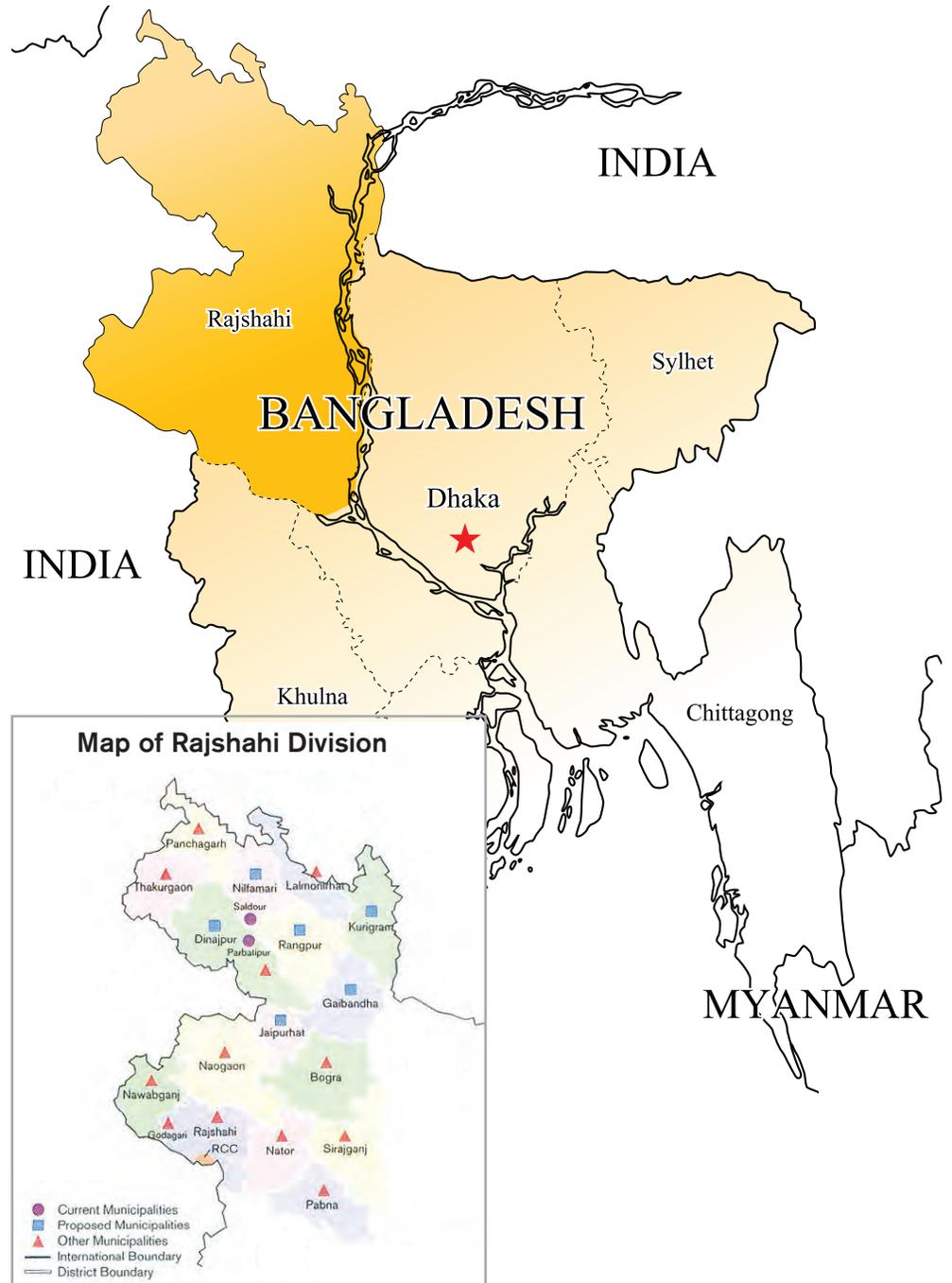
Recognizing that facility-based health services were not reaching those in need, and with no precedent for coordination among the existing actors, Concern saw an opportunity to leverag existing community resources within communities and worked with government actors to create a more favorable environment for healthcare. With support from USAID in 1998, Concern started a two-year pilot Child Survival Program in two small neighboring municipalities within adjacent districts of Northern Bangladesh: Saidpur (Nilphamari District) and Parbatipur (Dinajpur District). The initial intent was to test the efficacy of a capacity-building approach based on partnership with the two Municipal Health Departments to strengthen community urban health systems.

After a successful pilot, in 2000 Concern launched its first full Child Survival Program in Saidpur and Parbitpur. The project strengthened the organizational capacity of the Municipal Health Departments and, through them, the capacity of Ward Health Committees, who in turn, recruited, trained and supported a network of Community Health Volunteers at the community level. Reaching approximately 135,000 women of reproductive age and children under five, the pilot program emphasized ongoing evaluation and ultimately adopted a sustainability assessment framework to guide programming. Data showed that the health status and health knowledge of the target population improved significantly as a result of the program's capacity building and its targeted information sharing. Moreover, the Urban Health Model had a particular focus on improving conditions for extreme poor and vulnerable populations.

Saidpur & Parbatpur municipalities

1998-2000	2000-2004	2004-2007
Design planning	Original intervention	Learning center

Bogra, Dinajpur, Gaibandha, Joypurhat, Kurigram, Nilphameri, and Rangpur municipalities

2004-2009
Replication phase intervention
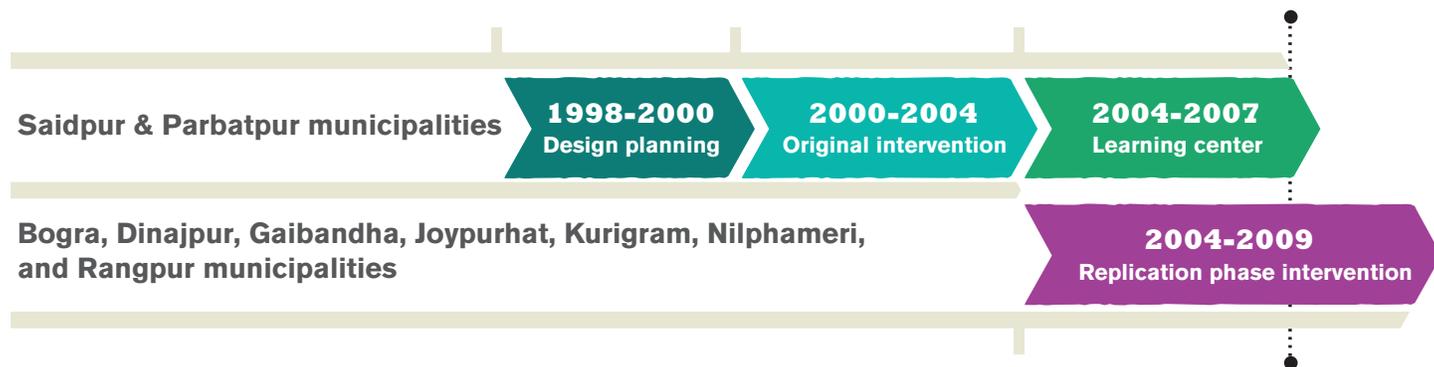
In 2004, the Saidpur/Parbatipur Child Survival Project came to a close. The following year Concern obtained funding from USAID for the Municipal Health Partnership Program, to scale up the initial intervention by introducing the same approach in an addtional municipalities in the northern region, reaching a population of over 865,000. The two original municipalities (Saidpur and Parbatipur) became Learning Centers and only received very limited inputs through 2007, and no support (financial, technical or other) thereafter until the program ended in 2009. Together, the nine municipalities included in Concern's urban health program reached a population of approximately one million people over a span of ten years.

CHAPTER 2

BEFORE YOU START – KEY CONSIDERATIONS

EFFECTIVENESS OF THE MODEL

Before anyone is interested in replicating all or part of an approach like Concern's Urban Health Model, they must first be convinced that it is effective. During the decade that the Urban Health Model was being developed and implemented, there was extensive monitoring of the health status among the target populations, as well as the capacity and effectiveness of the existing municipal and community organizations. urbanization compounds already harsh health conditions by increasing the risk of morbidity and mortality, especially among the poorest and most vulnerable.

Table 1: Results Summary of Health Intervention Outcomes[4]

Indicator	Baseline, %	Final, %	Target, %	Explanation
I. Child Health				
Knowledge of 4 danger signs for a sick child	15	60	35	Exceeded
Knowledge of danger signs of pneumonia	33	66	45	Exceeded
Knowledge of how to seek treatment for acute respiratory infection	45	58	60	Almost met
Prevalence of acute respiratory infection	17	7.6	N/A	Decreased prevalence (success)
Knowledge of danger signs of diarrhea	32	69	50	Exceeded
Use of oral rehydration solution	71	73	80	Almost met
Provide more food/liquids during diarrhea	38	27	50	Not achieved due in part to strong cultural practices
Prevalence of diarrhea	13	9	N/A	Decreased prevalence (success)
Mothers washing hands at 5 critical times	16	17	30	Not achieved due to strong cultural practices
Complementary feeding (6-11 months)	57	92	45	Exceeded
Vitamin A (12-23 months)	59	92	85	Exceeded
Immunization (12-23 months)	82	91	N/A	Increased

[4] Highlights of results achieved through the 2005-2009 Municipal Health Partnership Program. Please see the USAID Development Experience Clearinghouse at dec.usaid.gov for full versions of the mid-term and final evaluations.

Table 1: Continued

Indicator	Baseline, %	Final, %	Target, %	Explanation
II. Maternal Health				
Antenatal care – 3 or more visits	58	73	N/A	Increased
Iron supplementation (90 days)	42	52	60	Increased but not met
More food than usual during pregnancy	32	43	45	Increased and almost met
Knowledge of 5 pregnancy and labor danger signs	23	42	N/A	Increased
Delivery with Skilled Birth Attendant (SBA)	49	58	60	Increased and almost met
Vitamin A postpartum	25	49	50	Increased and almost met
Breastfeeding initiation (within 1st hour of life)	42	42	60	No change, strong cultural practices
Newborn immediately wrapped w/clean cloth	17	16	30	No change, unclear
Newborn care within 48 hrs after birth	24	45	N/A	Exceeded

In terms of the health interventions, sample surveys were conducted at baseline, midway into the life of the program, and at its conclusion. As demonstrated in Table 1, significant improvements were achieved. In many cases, results exceeded the end of project goals that were established prior to launching field activities.

Considering the reduced prevalence of diarrhea and acute respiratory infections among the target population, and using the Bellagio Lives Saved Calculator to predict the number of lives saved by assessing changes in coverage of key child survival interventions and baseline mortality rates (as estimated from DHS data), Concern was able to estimate the program's impact. The final evaluation reports that an estimated 1,077 child deaths were averted as a direct result of the program during the replication phase from 2005 through 2009 (this figure does not include child deaths averted during the start-up period from 1998-2004).

As illustrated in Table 1, significant knowledge and behavior change took place as a result of the Concern's urban health initiative. Although significant change did not occur in each indicator, which may have been influenced by strong cultural practices, the project still made significant life-saving improvements in the health status of target population. It is important to note that none of these improvements were generated by direct service provision. Instead, Concern's Urban Health Model built the capacity of existing government entities and local civil society organizations to more effectively utilize existing human and organizational resources to improve health systems coordination and, ultimately, service provision.

Core Components of the Urban Health Model

Build Synergy: Identify partners – a minimum of one substantial partner in the public and private sectors. Ensure that each partner is committed to capacity building as a key implementation strategy. Include multiple sectors (e.g., education, religious affairs, women's affairs), in addition to the health sector, to increase support and provide a multi-dimensional approach to improved health.

Be a Catalyst: Activate national and long-term community linkages to health services, instead of investing in short-term direct care.

Know Your Starting Point: Identify, reactivate and implement existing health policies.

Use What Works: Incorporate evidence-based best practices – such as Community Case Management or Community Management of Acute Malnutrition – in program strategies.

Invest in People: Build the capacity of existing human resources such Community Health Volunteers and trained birth Assistants to deliver life saving interventions, rather than investing in short-term material inputs.

Put the Least Advantaged First: Target the lowest socioeconomic and/or most vulnerable groups in the community. Often the most hard-to-reach, these populations are at the greatest risk for poor health outcomes, and present the greatest opportunity for impact.

Be Resourceful: Mobilize and strengthen existing resources, such as Ward Health Committees, teachers, and religious leaders, to drive community change. Recognize the value of volunteers from all sectors.

Give Everyone a Seat at the Table: Ensure equal representation and participation from all genders, socio-economic groups, ages, and backgrounds.

UNDERLYING PRINCIPLES

Two underlying principles form the backbone of Concern's Urban Health Model: A commitment to capacity building and a pro-poor framework. Each of these principles represents a key aspect of the model, and are what make the model not only effective, but also unique.

Capacity Building and Organizational Development as a Process

As noted above, Concern invested in existing human and organizational resources, rather than material inputs, to improve health services. Intensive capacity building is fundamental to Concern's Urban Health Model and is imperative if health improvements are to be sustained. Capacity building occurs at all levels: the capacity of the Municipal Health Department must be strengthened to ensure proper oversight and leadership in efforts to improve health. In addition, the capacity of local health committees and volunteers must be strengthened to implement and monitor effective health interventions. Capacity building is not a one-time event; instead it is a time-intensive, iterative process that will occur throughout the life of the program. The first step to building capacity is to get individuals to buy in to the idea that they must have their own capacities strengthened to more effectively serve their community, by using simple individual or organizational self-assessment tools, such as the Health Institution Capacity Assessment Process, which will be described in further detail in Chapter 3. Using self-assessment indicators, capacity building activities may be prioritized and key outcomes resulting from capacity building efforts can be measured. For example, the final evaluation of Concern's Municipal Health Partnership Program, found that as a result of intensive sensitization, advocacy, and capacity building efforts, the 2007-2009 Municipal Health Department budget allocation increased per population.

Top 5 Capacity Building Priorities:

1. *Participatory Planning*

2. *Leadership & Governance*

3. *Resource Mobilization & Management*

4. *Collaboration & Coordination*

5. *Monitoring & Evaluation*

Global evidence and Concern's decade of learning in Bangladesh point to the need to involve the community and give them a sense of ownership, while utilizing existing local personnel to assist in health improvement activities.

Pro-Poor Framework

Another unique and essential aspect of Concern's Urban Health Model is its focus on reaching the extremely poor and least advantaged groups. To do so, the Concern worked with the Ward Health Committees to define indicators for the least advantaged and most vulnerable households[5]. Using these indicators, Concern and the Ward Health Committees divided the municipal population into asset quintiles and developed a physical map to identify the location of these households. Concern and partners then utilized this list to ensure that services were specifically targeted to households in the lowest quintiles. In addition, the list was shared with other health and social service providers, thereby strengthening the social safety net.

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[5] Please see Annex A for a sample list of vulnerability criteria.

> *" Community Birth Assistants are helpful for us. Yesterday, a Community Birth Assistant brought four patients. Generally they bring the poor people.*

– Head of the Maternal and Child Welfare Center in Rangpur

Concern also used its pro-poor framework in its monitoring and evaluation system, to ensure that coverage and health outcomes were at least as strong among the poorest communities as in the rest of the population. For example, in Vitamin A distribution, coverage of the poorest segment of the population went from 50% to 92%, while among the best-off group it increased from 70% to 94%, which translates to a reduction of the equity gap from 19.7 percentage points to 2.5 percentage points. In addition, a composite of maternal child health indicators shows that the most significant improvements in health occurred among Quintile 1 (poorest), where health indicators improved from 28% to 41%, representing an improvement in health outcomes of almost 50%. This was followed by a 44% improvement for Q2 and almost 25% increase for Q3. A much smaller gain was seen for Q4, with no change among the richest residents. Overall the equity gap dropped from 29.9% to 16%.

The Urban Health Model demonstrates that improving health outcomes among the poorest and least advantaged groups is possible, when appropriately applying and measuring a pro-poor framework.

Achieving Equity

The final evaluation of the Municipal Health Partnership Program indicated that the model was successful in ensuring that messages and services reach the poor: there was an overall reduction in the healthcare equity gap from 29.9 percent to 16 percent, suggesting the extreme poor had improved access to services and information as a result of this collaborative work. Refer to Annex B for the complete equity analysis.

CHAPTER 3

IMPLEMENTATION STEPS TO ROLL OUT THE URBAN HEALTH MODEL

Concern and its partners have distilled the implementation of the Urban Health Model into 10 chronological steps that represent the key building blocks required for the model to be effective. This chapter details the importance of each step, and key considerations necessary for its successful execution.

Implementation Steps to Roll Out the Urban Health Model

1   *Secure Support from Top-Tier Leadership*

2   *Strengthen Mid-Tier Leadership Capacity*

3   *Establish and Strengthen Local Health Committees*

4   *Build a Volunteer Network*

5   *Train the Community Health Volunteer Network*

6   *Develop the Behavior Change Communication Strategy*

7   *Implement a Health Information Management System*

8   *Conduct Rigorous Monitoring and Evaluation*

9   *Ensure Sustainability*

10   *Consider Costs*

STEP ① Secure Support from Top-Tier Leadership

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

Identify Top-Tier Leadership – Who is Responsible?

Although Concern's Urban Health Model is a grassroots, community-led approach to strengthening health systems, buy-in from national level policy makers is critical to ensure that municipal and community level initiatives are supported throughout the life of the project, and beyond. Therefore, the first step to implementing the Urban Health Model is to map out key roles and responsibilities between top-tiered organizing bodies, such as the Ministry of Health and Family Welfare and the Ministry of Local Government. Identify who, at the national level, is responsible for policy development and resource allocation for the overall health of the target urban population. At a minimum, the following should be identified:

- ☑ The ministry responsible for urban development and planning policy
- ☑ The ministry responsible for health policy
- ☑ The body that each of the above ministries have delegated oversight responsibility to for the implementation of core health interventions at the district and/or municipal level

Identifying Top Tier Leadership in Bangladesh

In many country contexts, ministries may have overlapping roles, and urban health often falls in the gap. However, using the checklist above, Concern was able to map out key responsibilities and move forward in developing partnerships:

- ☑ The **Ministry of Local Government and Rural Development and Cooperatives** is responsible for urban development and planning policy
- ☑ The **Ministry of Health and Family Welfare** is responsible for health policy
- ☑ The **Municipal Health Department** (technically part of the Ministry of Local Government and Rural Development and Cooperatives) is delegated oversight responsibility for the implementation of core health activities at the municipal level; with coordination with the Ministry of Health and Family Welfare.

Once you've mapped the top-tier organizing bodies that are critical to the success of your program, identify the key representative from each body that will serve as a project liaison and collaborating partner throughout the life of the project. Often, these representatives will not be from the national level ministries, but from the municipal/district level at which your project is being implemented. At a minimum, the following individuals and/or bodies (such as management teams or committees) should be identified:

☑ The elected municipal/district level leadership

☑ The individual that liaises with regional and national level government health entities
and is in charge of the planning and supervision of all health activities in the district or municipality

☑ The individual or body in charge of supervision of medical staff and community health workers
at the health facilities in the target implementation areas

Identifying Representatives in Bangladesh

Although the titles of each official may vary, using the checklist above, Concern identified the following leaders from the Municipal Health Department that served as key partners throughout the life of the project:

☑ The **Municipal Cabinet**, including the Municipal Chairman (elected), Councilors (elected, one per ward), Female Councilors (elected, one per three wards), and Municipal Secretary (government employee), consistent of the municipal leadership

☑ The **Medical Officer** serves as the head of the Municipal Health Department and is responsible for supervising health staff. However, the Medical Officer position was often vacant, therefore Concern also liaised with the Sanitation Inspector, who served as the head of the Municipal Health Department in the absence of a Medical Officer

☑ The Municipal Health Department staff is mostly made up of vaccinators, who typically do not have any clinical skills other than immunization. Yet, vaccinators are responsible for delivering health services as a part of the local government and often have the best connection with the community, therefore a representative vaccinator should also be included as a key partner.

Align Expectations:
Conducting an Orientation for Identified Leaders

Once identified, the key representatives of the relevant ministries responsible for health and urban planning at the municipal level will serve as the project's main partners. Before moving forward with any other project activities, these leaders must be oriented to the project's objectives, proposed activities, and timelines. In addition, health data and key health challenges in the implementation area may be discussed, which ensures that all parties share the same mission to confront those challenges. At this important orientation meeting, the roles and responsibilities of each partner are delineated and plans for joint work planning may be developed.

In Concern's experience, leaders will often likely be very eager to collaborate, and will have many ideas for improvements. On the other hand, it is crucial that leaders understand from the beginning that they will not be receiving tangibles or hardware like new buildings (e.g. clinics) or supplies (e.g. vehicles or medical equipment). Instead, the project implementers must instill in each leader the key underlying principles of the project, especially the central commitment to capacity building and organizational development as a process at all levels.

The Importance of Relationships for Successful Partnerships:

The partnership development process does not occur in just one orientation meeting. Instead, this relationship-building requires months of official and un-official nurturing (including out-of-office social occasions) to ensure that project staff and partners feel like true allies. Implementers are encouraged to think of creative ways to win mutual trust and form strong alliances that will last through the life of the project.

The ultimate goal of an orientation meeting with the identified top-tier leaders is to build informed partnerships. Concern found that leaders and other key representatives who participated in the orientation meetings were quicker at organizing themselves to support the project, especially with regards to delegating project specific-tasks to key individuals, such as the mobilization and training of Community Health Volunteers. These leaders were also more effective at securing the support of their respective regional and national level superiors.

Seeing is Believing: How to Secure Collaboration

> *Seeing is believing- I didn't believe when Concern told me about the program but today after seeing all the issue I strongly believe that the program has great potential for coordinating the urban health actors for effective health delivery.*
>
> *– Director General, Ministry of Local Government*

Although many leaders are eager to collaborate, some may have not had positive experiences working on health and development projects in the past or may be skeptical that change is possible especially without the provision of material inputs. If your organization or another group is implementing a similar project in a neighboring municipality or even another part of the country, a short site visit to this project by key authorities is highly recommended. During the site visit, leaders will have an opportunity to see a similar project in action and interact with key project staff and beneficiaries. Most importantly, authority figures will be able to meet their counterparts and hear their positive impressions on how the project collaboration has improved health services and the health status of their constituency. The site visits provide the opportunity to turn abstract concepts such as 'mobilization', 'participatory' and 'capacity building' into to something real and tangible. Often, after a site visit, officials return home with a much clearer understanding and appreciation of what the approach is about and what is involved. These visits can be a truly eye-opening experience, as evidenced by their feedback. The Concern team received many comments like: *"Now I understand!"* and *"Seeing is believing."*

After each Learning Center visit, a daylong orientation is held with participants to debrief them on what they saw and learned, giving everyone an opportunity to share their observations, insights and opinions, while getting all of their questions answered.

Furthermore, throughout the life of the project, it is advisable to encourage municipal authorities to visit project sites. Concern has found that regular site visits and meetings with project implementation team members and key beneficiaries to observe practices and discuss issues and lessons learned is critical to the project's success. The visits provide a forum to share successes, and seek support for key activities; and ultimately ensure sustainability of the project.

The Value of Learning Centers

As explained in Chapter 1, Concern's Urban Health Model began in two neighboring municipalities, Saidpur and Parbatipur. These were the two municipalities that initially proved the efficacy of the community-based, participatory approach of the Urban Health Model. When the project was scaled up to seven additional municipalities, Saidpur and Parbatipur became "Learning Centers" where the new municipalities could visit to witness the activities proposed *in action*. In addition, the Learning Centers served as a technical resource to program implementers throughout the life of the project, as project staff were able to seek advice on how to resolve common issues.

Formalize the Partnership

Once the partnerships with key leaders have been solidified, a Memorandum of Understanding may be signed. In this document, representatives from each official government agency formally agree to the partnership roles developed, and key roles and responsibilities are delineated. Letters of support are also suggested for other key stakeholders even if they are not directly implementing activities.

STEP ② Strengthen Mid-Tier Leadership Capacity

Forming a Municipal Coordinating Team

In Step 1, top-tier leaders in the municipality and/or district were identified and engaged in the project. In Step 2, the specific individuals who are responsible for the overall municipal planning and coordination within their respective offices must also be identified and engaged. Often times, these individuals are already working in tandem, through a District Health Management Team, or other similar structure. In other instances, personnel responsible for oversight of community outreach, community health workers, medical staff, and urban planning may be working in a silo; without any meaningful coordination or communication between them. Another example may be that previous district or municipal level committees were formed for a specific initiative (e.g., as a support committee for an Expanded Program on Immunization) but have since become non-functional.

Regardless of the local context, a municipal/district level management team or coordination committee is critical to ensuring the overall success of the project; and therefore should be either formed or strengthened. The objectives of such a committee are to:

- Coordinate all health services and activities in the municipality or district provided by the Ministry of Health, Ministry of Local Government, civil society organizations, and private institutions
- Identify and reduce service gaps
- Ensure optimal utilization of existing resources
- Improve the quality of services provided
- Promote community participation

Members of the mid-tier leadership municipal coordinating committee would include key representatives from municipal health service providers, as well as the heads of each of the local health committees (described in Step 3 below).

Re-Activating the Municipal Essential Service Package Coordination Committee in Bangladesh

In 1995, the Government of Bangladesh mandated that a mid-tiered coordinating body called the Municipal Essential Service Package Coordination Committee be created in each municipality. These committees were meant to be responsible for strengthening urban health throughout the municipality, but this mandate was not well communicated, and no long-term action was ever taken. Concern's role was to re-activate this committee into a functional unit, and to ensure they had the capacity to meaningfully fulfill their mandate.

In order to ensure the success of these committees, Concern oriented top-tier municipal leaders on the importance of the Coordination Committee, as well as their expected roles and responsibilities, during the orientation meetings described in Step 1. As a result, during the scale-up of the Concern's Bangladesh Project, the Coordination Committees were formed in each municipality within one year of the project launch.

Becoming Operational and Building Capacity

Even if a municipal level coordinating committee already exists, their mandate will likely grow with the additional responsibilities as a key implementing and collaborating partner with the new urban health initiative. Therefore, building the organizational capacity of this committee to effectively fulfill its responsibilities is a critical activity, and one that will likely last throughout the life of the project. At the beginning, a participatory capacity assessment tool should be employed to measure the committee's core competencies in key organizational development areas such as: leadership and management, human resources, finance and administration, strategic planning, resource mobilization, and monitoring and evaluation. Based on the results of the assessment, key trainings and capacity building activities may be prioritized.

Concern's Health Institution Capacity Assessment Process

Several capacity assessment tools may be applied, including Concern's Health Institution Capacity Assessment Process (HICAP). The HICAP measures progress towards an 'ideal capacity,' as defined by the municipality leaders themselves, through 'possibility statements,' which define indicators for their own institutional competencies. Based on dialogue and participant consensus, groups may score their own progress in key competency areas on a five point scale. Ultimately, this process provides both quantitative scores on capacity areas and qualitative comments about municipality management, capabilities and operations. The HICAP is therefore a participatory self-assessment tool that may be employed as frequently as quarterly to measure progress in key areas, and often proves very useful to reinforce capacity building efforts. Please see Annex C for a full version of the HICAP Guidelines.

If the committee is being formed for the first time, or being re-established after a long latent period, the NGO implementing the Urban Health project should actively facilitate the initial meetings and provide support until it is apparent that the committee is making independent decisions and will not dissipate. In fact, even if the committee has been functional for some time, the implementing NGO may still desire to at least participate in the meetings, to ensure the new project is effectively integrated into municipal priorities. Ultimately, the high-level municipal/district leadership will be responsible for arranging the committee's regular meetings, and providing the support to implement key decisions and actions, and maintaining the committee upon the termination of the program. As part of the Urban Health Model's commitment to true capacity building, top-tier leadership will also receive technical support on running effective meetings and operating effective organizations.

1st Stage: Seed Sowing

In this stage, no results are visible, but the origin (the seed) exists. This seed represents potential and the fact that it has been put in the soil represents the initiative put forth for reaching a dream (the tree). As it is not visible, caregivers have less interest and give less attention to it, but continuous care is of utmost importance in order to attain the desired outcome.

Elementary/beginning stage of Capacity that implies the start of any project.

2nd Stage: Germinating

At this stage, the input (sowing the seed) has produced a small result (the seedling), which may grow into something much bigger if the necessary care continues to be given. Without this care, the eventual dream may not come to be. In this stage, caregivers are focused on this small result in order to keep it viable and to move towards the eventual dream.

2nd stage of capacity status is the possibility of achieving the future dream.

3rd Stage: Sapling
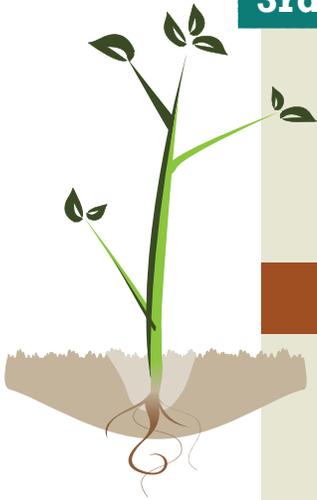
Through significant efforts over the time, the possibility of reaching the dream becomes more and more visible. At this point, the probability of the intended result has also sharply increased, and it becomes less vulnerable to destructive external factors. Caregivers begin to look at the growth of the tree within a broader perspective.

The growing-up stage gives hope for a greater future.

4th Stage: Maturing
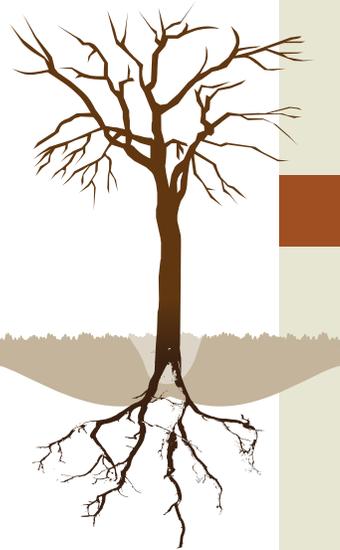
At this point, a series of mechanisms of inputs (roots and branches) result in increased strength and the likelihood of the eventual dream. As it matures through these systems, there is less of a significant threat for sustainability. Furthermore, all of the efforts and mechanisms that contribute to the growth of the dream become well-functioning and viable.

Significant results are in place in order to realize the eventual dream.

5th Stage: Fruit Bearing

The dream is realized through the commitment and continuous efforts of caregivers. The permanent changes and results have taken place. In the same way that a mature tree bears fruit, at this stage caregivers and people fully benefit from the results, and the tree, or the outcome, provides continuous benefits. Most importantly, there is very little possibility of the outcome ending.

The final stage of capacity is like a fruit- bearing tree that spreads the outcomes and continues by itself with its own maturity.
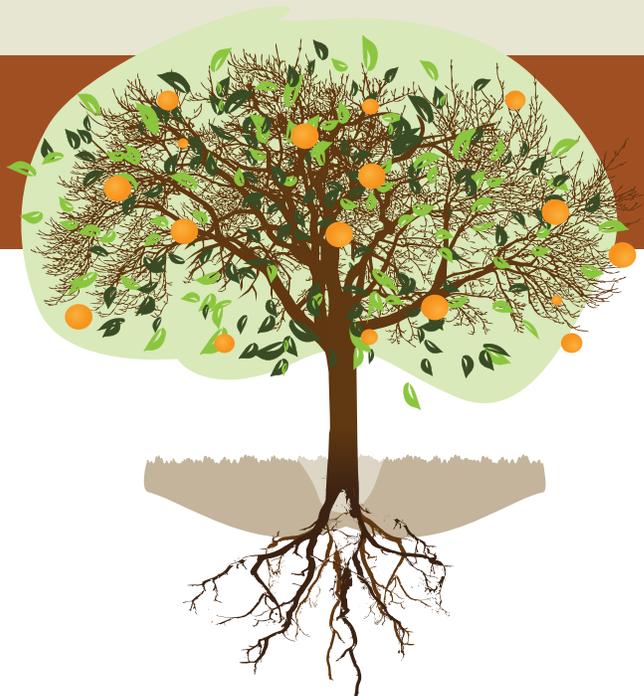
STEP ③ Establish and Strengthen Local Health Committees

What does the Local Health Committee Do?

While Step 2 focuses on the importance of establishing and strengthening municipal health coordinating committees, Step 3 focuses on the importance of local health committees. Operating at the community level, which may be called a 'ward' or 'zone', these local health committees work in hand in hand with the local health facility to plan, implement, and oversee the day-to-day local health activities. Some of the main functions of the local health committees are to:

- Plan and coordinate all health activities at the local level
- Support outreach for public health activities, such as World Health Day, National Immunization Day, and Safe Motherhood Day
- Supervise Community Health Volunteers
- Mobilize resources for local health activities
- Ensure a functioning referral network of public and private health facilities
- Set targets and conduct monthly and annual monitoring and evaluation data on activities implemented

In addition, the local health committee identifies the extremely poor and least advantaged households and ensures that these groups are encouraged to participate in local health programs and services; that they have access to health services; and that ultimately their health needs are met. If there is a family that needs care and they are unable to access that care, the committee is responsible for supporting the family in health emergencies through local level fundraising, utilizing community funds, or actively negotiating with a health facility to reduce costs.

Establishing Local Health Committees

Local health committees play a central role in supporting the day-to-day functions of local health activities, and are therefore a vital partner in the successful implementation of a community-based urban health program. In some instances, local committees are already fully functional, while in other instances no such entity exists, or is defunct.

Because the local health committees play such a central role in the community, it is essential that their formation is recognized by the community. To ensure this, the formation of the local health committee must be a participatory, transparent process that involves a broad representation of community members. The following steps are critical to ensure that the local health committee formed is accepted, and owned, by the community:

- **Agree, with mid-tiered leaders, committee membership criteria**
- **Conduct door-to-door outreach and meet with local civil society groups to proactively identify potential members**
- **Hold an information session for the community**
- **Nominate members to serve on committee**
- **Hold an orientation session for the new committee**

Urban Health Model Partners
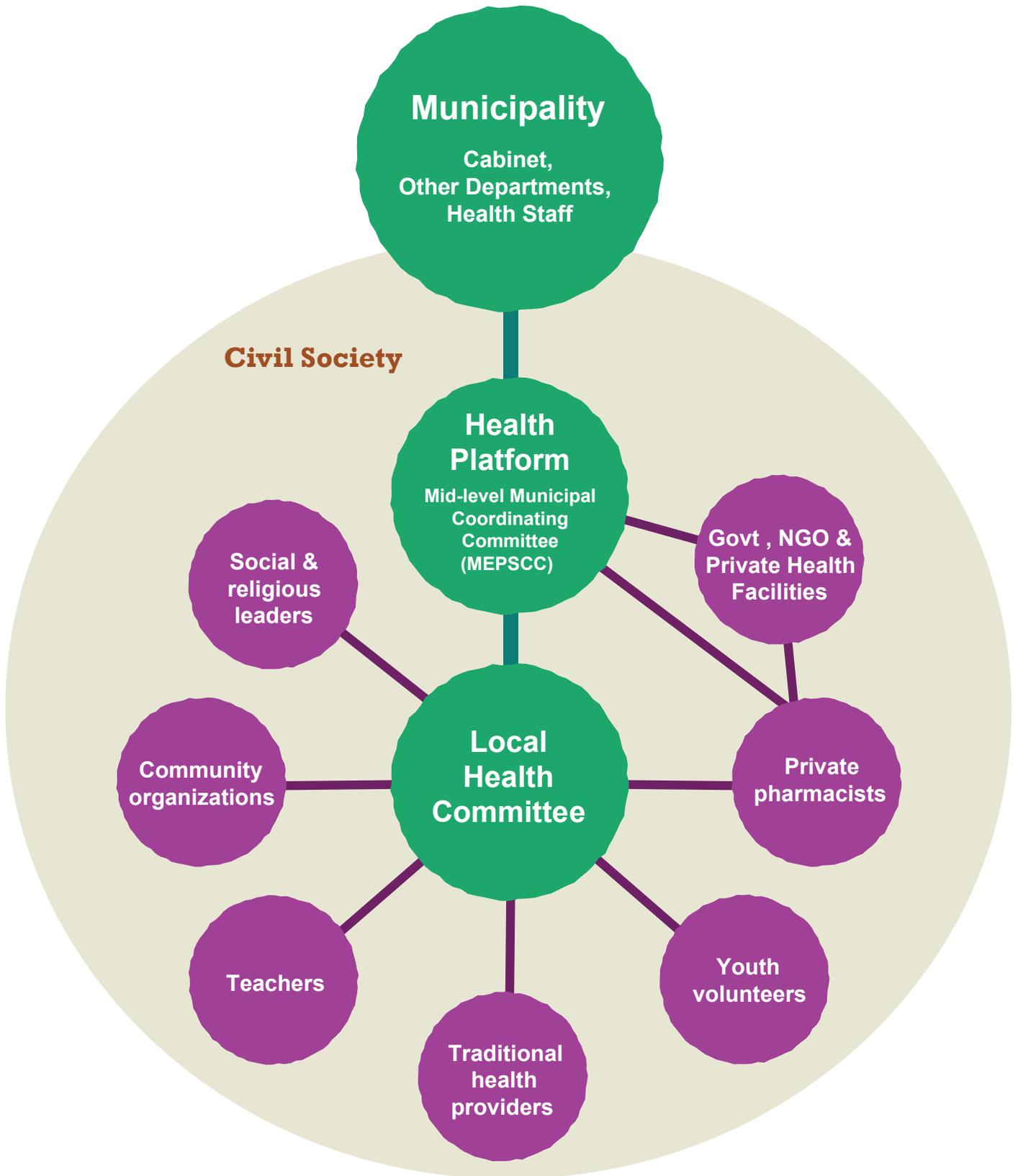
Possible Roles and Responsibilities of Local Health Committee Members

Ward Councilor

May be an elected representative. Leads and manages the committee (convening regular meetings, planning, providing follow-up and maintaining a participatory approach) and maintains contact with the mid-tier leadership coordination committee and municipality authorities.

Female Councilor

May also be an elected representative. Acts as a member of the committee and ensures participation from female community members; facilitates the decision-making process and contributes to the planning and follow-up process.

Municipal Health Department Staff Member

Assists the Ward Councilor in calling and organizing the monthly meeting, preparing the meeting minutes and facilitating the annual plan exercise and semi-annual reviews. Also works with the Community Health Volunteers in the preparation and presentation of the most recent service delivery data from the Health Information Management System.

Non-Governmental Organization (NGO) Representative

Provides regular updates on NGO activities and initiatives, coordinates committee and NGO health priorities. Also ensures that the NGO participates in special events and fairs (e.g., World Health Day).

Religious Leader

Serves as a representative of the faith community and raises awareness about important health issues in that community. Also stays in touch with other Religious Leaders inside and outside of the community.

Teacher Representative

Ensures that health messages for primary school students are disseminated and maintains links with other teachers regarding priority health topics or events.

Community Birth Assistant Representative

Takes a lead role among the Community Birth Assistants in the community and disseminates messages on health topics or events; also keeps committee members informed about harmful practices in the community and lets them know about any critical pregnancy or delivery among ward women.

Private Practitioner Representative

Represents the other Private Practitioners and Rural Medical Practitioners within the community, with a goal to reduce harmful cultural practices and to liaise with other service delivery personnel and referral units.

Political Savvy

One easy way to ensure that elected officials are engaged in the project without paying them remuneration is to link the project objectives with their own objective of serving people and "winning hearts" for their own political benefit. This is a win-win situation and the success in motivating elected officials depends on how effectively and subtly you communicate with them, and help them to understand this.

The formation process involves community-level meetings, as well as extensive dialogues with respected, motivated community leaders and government officials to explain the purpose and agree on membership criteria of the local health committee. Following these meeting, project staff go door-to-door to identify potential members who meet committee membership criteria. During these home visits, people are informed about the objectives of the local health committee and how they could contribute to improving the maternal and child health situation as a member of the committee. Municipal officials then invite individuals visited to attend an orientation session on the formation of local health committees. At the orientation, Municipal Officials outline the committee's objectives, explain its importance, and describe the criteria for membership/participation. Following the orientation, attendees nominate representatives from each role on the volunteer network (see table above and Step 4 below): Community Health Volunteers, Community Birth Assistants, Religious Leaders, Private Practitioners and Teachers. In the end, 15 to 25 local health committee members from different socio-economic strata are selected.

After members are selected, staff members and municipal councilors organize a preparatory meeting to further explain the objectives and plans for moving forward. An important part of the launch process is holding an information session, where the community is oriented on goals, has their questions answered, and – ultimately - provides its support. People may be alerted about the information session through interpersonal communications or the distribution of an invitational letter with a date, a list of potential participants and a meeting location. Concern found that anywhere from 50 to over 200 people showed up. Expect meetings to last 2 ½ to 3 hours (no more than 4 hours), so it is advisable to hold them after work hours or on a weekend to optimize attendance.

Putting Existing Policy to Work

In Bangladesh, the Ministry of Local Government and Rural Development and Cooperatives issued a Circular in 1995 stating that Ward Health Committees be established, and be responsible for promoting local-level health planning, implementation and monitoring of primary healthcare services, health awareness, coordination of health activities, and improvement of access to health services. However, the government never issued guidelines regarding the formation of these committees, and Ward Health Committees were never fully developed. This existing but inactive policy served as an entry point for Concern's urban health pilot program, enabling Concern to take the initiative to reactivate Ward Health Committees in two municipalities. Since then, nearly 100 Ward Health Committees have been formed and are now effective child survival and health program managers and implementers in the nine municipalities.

Getting Started: First Steps

Following the successful nomination of committee members, an initial three-day orientation workshop is advisable. In this workshop committee members receive initial training on basic health topics, how to manage committee affairs, how to supervise community health workers, and how to monitor program performance. Following this orientation workshop, the initial activities of the local health committee are to:

- Create an annual plan/agenda for health activities and desired health outcomes
- Establish a monthly meeting schedule to discuss community health issues, review budgets and consider the resources available to the community
- Identify an office and place to meet (ideally in or near the health facility; or a local school)

Building Capacity

As with the mid-tiered district management or municipal coordinating committee described in Step 2; even if a local health committee is already functioning, their mandate will likely grow with the additional responsibilities as a key implementing and collaborating partner with the new urban health initiative. Therefore, building the organizational capacity of this committee to effectively fulfill their potential will be an on-going activity throughout the life of the project.

The HICAP tool described in Step 2 may also be utilized with local health committees. The on-going self-assessment process serves as a road map to prioritize capacity building efforts and to continuously monitor and evaluate capacity improvements. For newly established health committees, it may safely be assumed that the

following are key organizational development priorities, and may be implemented during the orientation session, even before any official assessment process begins:

- How to develop meeting agendas
- How to hold effective meetings
- How to develop annual plans
- How to effectively mobilize local resources
- How to maintain committee leadership through transition
- How to ensure active membership participation

Common Challenges

While local health committees form the central partner of any urban health model, their formation is not simple. The following are some frequent challenges that arise in the formation of local health committees that implementers may expect to encounter:

- Lack of buy-in from mid-tier and top-tier leadership: Without proper sensitization in Steps 1 and 2 to the role and importance of local health committees, mid-tier and top-tier leadership may not fully support local health committees. This lack of buy-in is often indicated by a lack of sufficient funds allocated to support local health committee activities and operating costs.

- Inactive membership: It is inevitable that some elected committee members will become inactive. Poor participation negatively influences the effectiveness of the committee and, therefore, inactive members must be replaced. The identification and orientation of new members should be viewed as an ongoing process.

STEP (4) Build a Volunteer Network

Concern's Urban Health Model is dependent on the mobilization of thousands of volunteers who implement many of the model's key strategies and activities aimed at improving the health status of their respective communities. While it is common for many community-based health programs to work with Community Health Volunteers and Community Birth Assistants, Concern's Urban Health Model also leverages the support of Private Practitioners, religious leaders, and teachers who serve as change agents in the community; reinforcing the model's strategies and activities and mobilizing support from their respective constituencies. This chapter explains the role of each volunteer in the urban health model's volunteer network.

Volunteer Remuneration?

Concern does not provide material incentives for the members on the volunteer network. Instead, Concern has found that the recognition and respect from the community, as well as the skills building that volunteers receive through their role with the project, is a highly motivating factor. Volunteers learn communication and leadership skills, and also acquire knowledge for their own health and that of their family. This experience also serves to prepare these volunteers for future professional roles in the healthcare field.

Concern's Volunteer Network in Bangladesh

Concern's Municipal Health Partnership Program, volunteer network trained 5,498 volunteers in nine municipalities:

- 4,201 Community Health Volunteers
- 384 Community Birth Assistants
- 236 Private Practitioners
- 397 Religious Leaders
- 280 Teachers

Who Can Serve on the Volunteer Network?

Although the roles of volunteer network members may vary, the following criteria may be useful in selecting volunteers:

- Interested persons who have completed a minimum of 8 years of education
- Interested persons 15 years of age or older (youth must have consent of their parents)
- Interested persons who are accepted and respected by the community
- Interested persons who reside in the particular neighborhood where they would be working and have the ability to be in regular touch with assigned households
- Interested persons who express an energetic interest in serving others without any financial remuneration

Community Health Volunteers

Even in urban areas, health centers may be inaccessible due to distance or the cost necessary for transportation to reach them. Therefore, Community Health Volunteers play a critical role in bringing key preventative and curative health services to the household level, and ensure that acute cases are promptly referred for follow-up care. Community Health Volunteers also play a critical role in disseminating health messages, implementing the local health committee agendas, linking the community to health services and facilities, and communicating with other volunteer network members on health issues.

Who are Community Health Volunteers?

Community Health Volunteers are individuals who live and work within the community they "care" for. They may be mothers, fathers, grandparents, or youth.

While many people assume that Community Health Volunteers are only female, efforts to promote a gender balance in the selection of Community Health Volunteers ensures that males are well-represented as well. Male Community Health Volunteers de-stigmatize the assumption that health is a woman's responsibility, and serve as a positive role model for their peers. Youth of both genders are also valuable additions to the community volunteer network; the healthy behaviours learned at an early age are critical to the health of their own families and that of their peers.

What do Community Health Volunteers Do?

Each Community Health Volunteer is responsible for a defined number of households in their community. In urban settings, which are much more condensed, Community Health Volunteers may have as many as 50 households within their purview. The Community Health Volunteer is expected to make a minimum of monthly visits to households with pregnant women and children under five years of age to provide personalized preventative health messages (e.g., on the importance of hand-washing, the use of bed nets, immunizations). If a sick child is identified during a household visit, the Community Health Volunteer may provide basic curative services (e.g., oral rehydration solution for diarrhea, counselling on continued feeding). Community Health Volunteers are also trained to recognize key danger signs associated with diarrhea and acute respiratory infections, and refer or accompany parents and children to the nearest health facility for further treatment when necessary. Community Health Volunteers also screen for danger signs in pregnant women, and provide targeted pre- and post-natal counseling and care. Community Health Volunteers don't just make home visits; mothers or fathers with a sick child may also come to the home or call a Community Health Volunteer when necessary.

Community Health Volunteers may be supervised by municipal health staff, or by the local health committee. In either case, Community Health Volunteers will collaborate closely with both entities, through joint planning, implementation, and monitoring of community-based health activities. As will be explained in detail in Step 7, 'Establish a Health Information Management System,' Community Health Volunteers also collect population-based data on births, deaths, illnesses, and pregnancies that is reported to the health facility, which ultimately is aggregated with other district/municipal level health data. These data are also used to monitor health trends in the community, and inform the Community Health Volunteers' health promotion activities and messages.

Community Birth Assistants

Pregnant women face similar barriers to accessing important pre- and post-natal services at health facilities as they do when seeking care for their sick children. In addition, in many countries giving birth at home, instead of at a health facility, is a cultural norm. Therefore, Community Birth Assistants play an important role in screening for danger signs and ensuring women attend antenatal care during pregnancy and following up with women immediately after birth, to ensure newborn survival. Community Birth Assistants are an important part of the community volunteer network as they are able to leverage the trust from women in the their communities to link them with proper labor and delivery services at the health center.

Who are Community Birth Assistants?

Just like Community Health Volunteers, Community Birth Assistants are members of the community that provide pre- and post-natal and referral services to pregnant women in their neighborhood. In many instances, functioning Community Birth Assistants may already exist, as this is often a role that is passed through families and generations. When selecting new individuals to serve as Community Birth Assistants, the following criteria may be applied:

- Individual is respected member of community
- Individual is interested in maternal and infant health
- Individual's children are in good health (fully immunized, not malnourished, etc)
- If the individual already serving as a community midwife, individual agrees to no longer promote herself as such

Some programs have advised selecting only married women with children to serve as Community Birth Assistants. However, Concern's Urban Health model found that the energy, commitment, and willingness to learn among adolescent women far out weighted the cultural prejudices which assumed young women were unreliable and lacking in credibility. In fact, just as with Community Health Volunteers, young women who serve as Community Birth Assistants provide an excellent opportunity to influence embedded cultural practices, and, eventually, re-define cultural norms.

Traditional or Skilled Birth Attendant?

In Bangladesh, the government provided a 21-day training course for individuals serving as traditional birth attendants in their communities; that is, those who were currently providing midwifery services but had not ever received formalized training. The objective of the 21-day course was to make deliveries safer and more hygienic. Recently, the Government of Bangladesh decided to revise this strategy and to start training a cadre of skilled birth assistants from among the government female health workers at the community level. Skilled Birth Attendants undergo a six-month, skills-based training that follows a standardized national curriculum.

Unfortunately, the government's abandonment of the training and official recognition of 'traditional birth attendants' for the 'skilled birth attendants' damaged the reputation of traditional birth attendants. While it is appropriate for skilled birth attendants to have a title that reflects their training, the shift in government policy left traditional birth attendants appearing as 'less than', or 'not good enough'. Consequently, based on suggestions from a national steering committee, it was decided that these paraprofessionals would be referred to as Community Birth Assistants.

While skilled birth attendants were used per government policy to provide home deliveries, Community Birth Assistants played a valuable role in Concern's Municipal Health Partnership Program. First, Community Birth Assistants served as reliable and important linkage points between the community and health facility. Second, by incorporating Community Birth Assistants into the program's network, it ensures that more modern birthing practices are promoted gradually introduced.

What do Community Birth Assistants Do?

Overall, the Community Birth Assistants' main responsibility is to promote deliveries at the health facility. Community Birth Assistants identify pregnant women in their community, and, instead of performing home deliveries as they traditionally did, they now are trained to identify danger signs during home visits and to either refer or accompany mothers to health facilities for antenatal care and delivery. In this capacity, Community Birth Assistants serve as outreach workers for the heath facility and increase patient flow to the health facility. In return, health facility staff may provide Community Birth Assistants with on-the-job training and regular monitoring/supervision by teaching them more about danger signs and accompanying them on home visits. This two-way relationship between Community Birth Assistants and health facility staff builds mutual trust; Community Birth Assistants feel they are an extension of the health facility, which brings them additional respect within their community, while health facility staff become more confident in the important skills Community Birth Assistants bring to bear.

In addition, Community Birth Assistants counsel the family members to develop a birth plan, which may include saving money for transportation or identifying other relatives to watch their children while they are away.

Evidence of Success:
The Role of the Community Birth Assistant

The role of Community Birth Assistants in providing key behavior change messages and making referrals to health center leads to improvements in key maternal health indicators. As described in Table 1 in Chapter 2, through the use of Community Birth Assistants, Concern's Municipal Health Partnership Program:

- **The percent of women who attended at least three antenatal care visits increased from 58% to 73%**

- **The percent of women who received Vitamin A post-partum increased from 25% to 49%**

- **The percent of women who knew five or more danger signs pregnancy and delivery increased from 23% to 42%**

Finally, like all members of the volunteer network, Community Birth Assistants play a role in data collection for the Health Information Management System described in Step 7. Their data collection focuses on the collection of pregnancy data, including the number of live births, and number of infant deaths.

Private Practitioners

In many countries, parents often take sick children to a private practitioner, who may be the neighborhood chemist who works at a small pharmacy kiosk at the nearest corner. These Private Practitioners often have little to no formal training in maternal and child health. Concern's Urban Health Model suggests incorporating Private Practitioners in to the community volunteer network. By doing so, Private Practitioners may be trained in how to prevent misdiagnosis and to stop promoting harmful practices, while leveraging their recognized role in the community.

Pregnant Mother and Neonate   SI No

Referral Slip
Please refer in time and save life

Mother/Neonate's
Name : . . . .

. . . .

. . . .

Father/Husband

. . . .

. . . .

Retained placenta
Unusual presentation
Eclampsia
Delayed Labour
Problems of Neonate
Others

Address:...................
Ward..
Municipality:.................

Private Practitioner – Friend or Foe?

It might seem counterintuitive that a private practitioner would collaborate closely with the health system, which, in the scenario of a developing country, may be thought of as a competitor. But Concern's discussions with Private Practitioners revealed that they are eager to be accepted as legitimate health care provider. If a Private Practitioner can say that he has been trained in child health by the public health system, respect for his skills and knowledge increases. Private Practitioners also recognize their limitations and often fear that they might mistreat a patient and that a child might die as a result. Incorporating Private Practitioners into the community volunteer network decreases the danger of adverse effects. In fact, experience has shown that when Private Practitioners refer accurately and effectively it improves their performance overall.

Who are Private Practitioners?

In an urban community, there may be a private practitioner on nearly every corner, and it may be unrealistic to include all of them in the community volunteer network. Therefore, the first step is to contact the municipality or district office responsible for the registration of such entities, and to acquire a complete list of Private Practitioners registered. At the same time, community members may be interviewed to collect suggestions on which Private Practitioners may be selected for inclusion. Ultimately, the local health committee will decide which Private Practitioners to target for participation, and the criteria for their selection may be based on geography (ensuring each sub-district/ward has at least private practitioner represented) and/or interest of the private practitioner himself.

What do Private Practitioners Do?

Private Practitioners are often untrained health practitioners who lack necessary medical skills yet provide treatment for illnesses. Therefore, Concern's Urban Health Model invests in upgrading their clinical knowledge and skills in child health to help them identify and refer cases of child health emergencies which require treatment at a health facility rather than at home. Private Practitioners that are incorporated into the community volunteer network agree to work within the guidelines and training they have received from the program. Specifically, Private Practitioners agree to treat children under five according the standards established under the Integrated Management of Childhood Illnesses (IMCI) framework. This agreement is not legally binding, but it does align Private Practitioners closer to government health providers and increases the chances that they will collaborate with the health system. In addition, Private Practitioners are provided with referral slips, which further strengthen linkages with the health facilities and ensures that children in need of additional care are encouraged to seek it out. The referral slips are also an incentive for Private Practitioners to join the program, as they are proof of the private practitioner's good standing in the community.

It is also recommended that Private Practitioners are made part of the local health committee, and that their work is closely aligned with that of other members of the community volunteer network, particularly Community Health Volunteers and skilled birth Assistants. By taking part in local health committee meetings, Private Practitioners learn about health challenges facing the community, are able to participate in planned health activities, and, overall, become a recognized asset and ally. Ideally, once fully trained and incorporated in to the community volunteer network, Private Practitioners deliver the same health promotion messages as other members of the community volunteer network, thereby helping to increase community awareness and improve health practices.

Religious Leaders

Religious leaders must be included in the community volunteer network, as they are an important channel for the dissemination of maternal and child health-related messages. Religious leaders can be helpful in convincing those who resist change on account of superstition or certain religious beliefs. At the same time, involving religious leaders in the health program ensures that these important community role models appreciate modern health advancements and do not spread counterproductive or conflicting ideas and messages.

Who are Religious Leaders?

Religious leaders are highly respected members of the community that can be an effective advocate and agent of change. As a member of the community volunteer network, the religious leader serves as a member of the local health committee. In areas where the vast majority of the population practices only one religion, for example, Islam, one Imam may sit on the local health committee. If there are other prominent religions in the community, it is important that their respective religious leaders are included on the local health committee as well. To select appropriate individual(s) for this important role, the local health committee may call a meeting of interested religious leaders and explain their role as a member of the volunteer network, concentrating on his responsibility for health message dissemination. Once the religious leaders agree, they receive training in key maternal and child health practices.
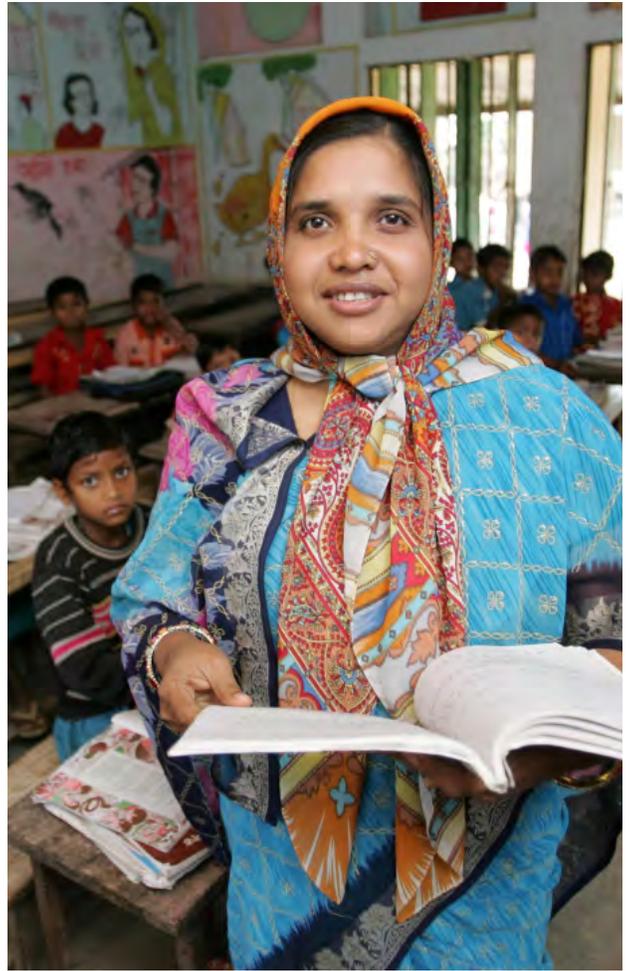
What do Religious Leaders do?

As members of the local health committee, religious leaders are able to implement the local health committee's planned activities directly with their congregation. For example, religious leaders may incorporate maternal and child health messages into prayers or sermons. In addition, religious leaders may participate in activities such as National Immunization Day and World Health Day which lends credibility to these community events.

Religious leaders may also provide personal counseling to persuade reluctant individuals to take steps recommended by health practitioners. For example, parents who are reluctant to get their child immunized because they think it is dangerous can be shown by someone of authority that these health practices do not have to be in conflict with their religious beliefs. Religious leaders encourage community members to seek help or treatment at health facilities, recognizing that there are limits to what spiritual treatment can provide.

Teachers

Teachers are another important community resource that, when trained and incorporated into the local health committee, increases the reach of the urban health program. Recognizing that children are also effective agents of change, and that primary and secondary school teachers are often mothers and fathers themselves, training teachers in the community to integrate topics on personal hygiene and danger signs of childhood illness (primary school) and safe motherhood and HIV&AIDS (secondary school) into their curriculum is a cost-effective practice to disseminate key messages.

STEP (5) Train the Community Volunteer Network

> *Recently a Community Health Volunteer identified complications in a pregnant woman in her zone. She counseled the mother and was able to convince her that she needed to go to the Maternal and Child Welfare Center. The Community Health Volunteer requested the Ward Health Committee to provide [money for] transportation, which they did. The child was delivered successfully and both mother and child are doing well.*
>
> *– Kurigram, Ward 5*

As noted several times, Concern's Urban Health Model focuses on extensive capacity building to leverage existing human resources rather than provide material inputs, such as the construction of clinics or the provision of vehicles. For the community volunteer network members to be fully effective in improving the maternal and child health status of women and children in their community, they must be trained with the necessary knowledge and skills. Once equipped, members of the community volunteer network are powerful change agents who may speak confidently with their peers and liaise with the health facility to accomplish the project's objectives. This chapter details the training required for each member of the volunteer network: Community Health Volunteers, Community Birth Assistants, Private Practitioners, Religious Leaders, and Teachers.

To enhance the knowledge, skills and capacity of the municipal health staff as health service providers, facilitators and promoters, the Concern conducted a training needs assessment with municipal health staff in each Municipality. Subsequently, the training of trainers (TOT) curriculum and training modules were developed, based on the training needs assessment, and utilized to conduct TOT courses. For sample training outlines for each of the groups described below, please see Annex D.

Training Community Health Volunteers

Community Health Volunteers are trained in a variety of topics related to the prevention and treatment of common maternal and childhood illnesses, as well as how to conduct effective home visits, collaborate with the health facility and their responsibilities as part of the greater community volunteer network. The following specific topics may be covered:

- Basics of Integrated Management of Childhood Illnesses (IMCI)
- Danger Signs: Fever, Diarrhea, Acute Respiratory Infections
- Safe motherhood
- Newborn care
- Nutrition
- Micro-nutrients (vitamin A, iron, iodine)

- Expanded Program on Immunization
- HIV and AIDS
- Behavior change communication
- Gender equity
- Role of the Municipal/District Health Department
- Role of the local health committees

Each topic may be covered in one-two hours, with time for questions and answers. Bear in mind that this training may be the first time Community Health Volunteers have learned some of this information, and it can be a lot to absorb at once. Implementers may choose to gradually introduce training topics on a monthly basis over the first year of the project.

It is also important to note that Community Health Volunteer capacity building does not stop at the end of one training. Community Health Volunteers must receive constant updates and reinforcement of what they have learned, through refresher trainings, on-the-job training, and supportive supervision visits. The local health committee should work with the health facilities and mid-tier leadership to assign health facility staff to ensure Community Health Volunteers are consistently providing correct information through their home visits and referrals.

After Community Health Volunteers complete their training, they receive a certificate and identification card. The identification card is an effective means of providing Community Health Volunteers credibility, and helps them gain the trust and respect of families with whom they will be working. The identification cards are also proof that the Community Health Volunteers are tied into an official body, and are a reliable go-to source for preventative and curative health care.

Training Community Birth Assistants

Training for Community Birth Assistants is usually conducted over the course of three weeks, and it is recommended that health facility staff participate directly in the training, potentially as trainers. Topics covered during the community birth attendant training may include:

- Antenatal Care
- Postnatal Care
- Safe Delivery Options
- Pregnancy and Delivery Danger Signs
- Reproductive Health/Family Planning
- Basics of Infant/Child Health

As with Community Health Volunteers, Community Birth Assistants will require frequent refresher trainings and on-the-job mentoring. Eventually, these on-going trainings should be organized by health facility staff.

Training Private Practitioners

Training for Private Practitioners ensures they are responsibly selling appropriate drugs, that they are able to provide targeted health promotion messages, and that they are capable of making referrals to the health facility when necessary. It is best if the Medical Officer from the district/municipality conducts the training for the Private

Practitioners, as this links the private practitioner to the health facility from the beginning. The following topics may be covered:

- Counseling the Mother
- Assessing General Danger Signs for Referral
- Respiratory Infections
- Diarrhea
- Malnutrition
- Fever and Infection
- Sickness in a Very Young Child

The last part of the training is the signing of agreements between the local health committee and the Private Practitioners. The practitioners agree to treat children under five according to the Integrated Management of Childhood Illnesses framework. The contract between Private Practitioners and the Urban Health Model is not legally binding, but it does bring the Private Practitioner closer to the government health providers, and increases the chances that they will collaborate with the health system.

As proof that they have completed this training, and are participating in the program, Private Practitioners are provided with a book of referral slips, which are given to patients as a means of facilitating the referral process to/from health clinics and hospitals. The referral slips are also an incentive for Private Practitioners. These slips send a message to the public that a practitioner has been recognized as being a quality provider, and that he has knowledge of, and access to, more advance health services if necessary. This makes a practitioner more reputable, and competitive – improving both their standing in the community, and the success of their business.

Concern has drafted a very detailed facilitator's manual for private practitioner training; the manual is available upon request. As in the case of the Community Health Volunteers and Community Birth Assistants, Private Practitioners also gather for refresher trainings and may receive supportive supervision.

Training Religious Leaders

The goal of training Religious Leaders is to enable them to spread health promotion messages, dispel harmful beliefs and practices, and lend credibility to the overall project's public health efforts. The following topics may be covered during training for Religious Leaders:

- Municipal Health Department Roles and Responsibilities
- Local Health Committee Roles and Responsibilities
- Basic Health Issues
- Expanded Program on Immunization
- Nutrition/Malnutrition
- Identification and Response to: Acute Respiratory Infection and Diarrhea
- Safe Motherhood
- Newborn Care
- HIV and AIDS Message Dissemination
- How Religious Leaders Can Make a Difference in Healthcare

Training Teachers

Teachers are trained to educate students on the following key maternal and child health topics in the classroom setting:

- Personal Hygiene
- Integrated Management of Child Illness
- Danger Signs of Diarrhea, Malnutrition and Acute Respiratory Infections
- First Aid
- Basics of Eye and Ear Infections
- Safe Motherhood (secondary schools only)
- HIV & AIDS (secondary schools only)

In order to ensure the successful implementation of this activity, it is also important to liaise with the district/municipal education office to ensure buy-in.

STEP 6 Develop a Behavior Change Communication Strategy

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

– Municipal Cabinet Member, Parbatipur

Defining Behavior Change Communication

Behavior Change Communication is messages delivered through a variety of channels that promote a specific set of behaviors to a targeted set of individuals. In the case of the Urban Health Model, behavior change communication provides messages about good health practices and the prevention of key maternal and child illness to a primary audience of women of reproductive age, particularly mothers and caretakers, and a secondary audience of husbands and other family members who are involved in health practices and care-taking decisions. These messages are then promoted through members of the community volunteer network, posters in common gathering points in the community, and on the radio.

Developing a Community-Specific Behavior Change Communication Strategy

Before developing any specific messages or media, program implementers must facilitate a process of deciding which key health behaviors should be promoted, and which audiences should be targeted. Concern's Urban Health Model promotes a participatory process that involves mid-tiered leadership as well as the local health committee and volunteer network who together to define health problems in the community, brainstorm healthy behaviors that would improve the problem, discuss barriers to implementing the healthy behaviors, and identify specific actionable messages accordingly.

One tool to facilitate this process is the BEHAVE Framework. This framework organizes the behavior change discussion by spelling out:

- The health problem (e.g. malaria)
- The health behavior to be promoted (e.g. seeking treatment within 24 hours of a fever)
- The target audience (e.g. mothers)
- Barriers to implementing the health behavior (e.g. health facility is too far)
- The specific message to be developed to promote realistic solutions (e.g. if your child has a fever, visit the Community Health Volunteer in your neighborhood within 24 hours)

Please see Annex E for a sample BEHAVE Framework. Using this information, the behavior change communication strategy may deliver simple, actionable messages that are based on determinants of behavior change, such as cultural attitudes and norms, perceived risk, and self-efficacy, to craft specific behavior change messages.

Once key health behaviors that will be promoted are identified through participatory processes, it is important to field test the corresponding messages with the targeted community and modify as required, in order to optimize their effectiveness.

Implementing Behavior Change Communication Activities

Once finalized, Behavior Change Communication messages are integrated through various communication channels, including one-on-one counseling and home visits from Community Health Volunteers, Community Birth Assistants, and Private Practitioners; and larger group communication through sermons and lessons by religious leaders, teachers, or other community leaders. Print communication materials, such as posters and flyers, may be developed and placed at key gathering points in the community, such as the water pump or health facility. It is important that all print materials developed include pictures, and are appropriate even for those with low literacy. Radio spots may also be appropriate. Finally, special events publicizing priority health messages are used to increase community and individual awareness about beneficial health behaviors, and available health services. One example is health fairs where "Best Father and Mother Awards" are presented to showcase positive knowledge and practices, as well as to serve as an incentive for other parents to replicate desired behaviors.

Behavior Change Communication Risks and Opportunities

Implementing a Behavior Change Communications strategy is to embrace a social mobilization approach to behavior change. Mobilizing society towards change can be time-consuming, frustrating and risky. Urban areas can be fragile due to high mobility, insecurity/social tension and less social cohesion. Working with government structures and catalyzing social change requires a significant effort. Building champions for change can also be tenuous, due to rapid political turnover and opposing political powers in the community. However, one major benefit of Concern's community-based approach, which involves a number of change agents and institutions, is that everyone in the program is spreading the same messages. Although the process can be time intensive and challenging, Concern leverages a diverse cast of community actors to build capacity and mobilize the community which has produced low cost, high impact, live-saving results. Adoption of desired behaviors is a sustainable solution to addressing adverse health issues opposed to delivering a tangible, curative good. Furthermore, coordination and collaboration among the various actors means that key messages will be constantly repeated and reinforced from multiple directions.

STEP 7 Implement a Health Information Management System

One of the more unique aspects of Concern's Urban Health Model was the development of a Health Information Management System. In many instances, health data is only collected at the health facility level, and is then aggregated at the district/municipal level, before ultimately being sent on to the national Ministry of Health or other statistics bureau. Critical information on community health indicators, such as incidence of disease and uptake in services, is therefore unavailable to mid-tier leadership and local health committees who are responsible for planning and implementing community-based health programs. This Health Information Management System is designed to augment health facility data collection, provide standardized and regular feedback to municipalities and communities on how the health program is working, and is an integral part of the larger project monitoring and evaluation system (described in Step 8).

Developing a Health Information Management System

In Concern's Urban Health Model, Community Health Volunteers and Community Birth Assistants are responsible for conducting household data collection during each home visit. On a monthly basis, local health committee members assist Community Health Volunteers and Community Birth Assistants in compiling these data into a standard summary sheet. The local health committee then submits the data to the district or municipal health department, while maintaining copies of the data for local use.

It is important to emphasize that the Health Information Management System is not designed to be a parallel system to that of the Ministry of Health. It is designed to complement and strengthen the data that is already being collected. As stated above, the data is also shared with the Ministry of Health and, where possible, the same data collection forms are used or adapted. Municipal level health staff also play a key role in training Community Health Volunteers and Birth Assistants in the data collection processes, and periodically accompanies volunteers on their data collection home visits to ensure quality in data collection.

Data Collected by Community Health Volunteers at the Household Level

- **Births and deaths**
- **Pregnancies**
- **Incidence of childhood illness**
- **Vaccination schedule**

- **Vitamin A coverage**
- **Method of family planning used**
- **Type of water source**

Data Use

Data is only worth collecting if it is analyzed and applied to program planning. Once submitted and compiled, the municipal/district health department conducts an analysis of the data and provides a monthly report to all stakeholders, including the local health committee, and mid-level district or municipality health team. This report is then used to guide a discussion on which aspects of the program may be lagging, and where further training or reinforcement is required. It also allows the local health committee to identify community volunteers who are having difficulties and need additional supervision and support, or those that are doing particularly outstanding work, allowing the local health committee to explore the techniques and approaches those volunteers are utilizing and whether these could be adopted by other volunteers. Ultimately, the data is used to inform decision-making and serves as the basis for annual plans.

A Functional Health Information Management System – Can it really be done?

Initially, there were some doubts that the Community Health Volunteers could collect or understand the data in order to make use of it. This concern proved unfounded – the Community Health Volunteers performed well in data collection and a number of them have subsequently been hired by other programs that require community-based information. The local health committee and Community Health Volunteers also interpreted and used the data correctly. As an added benefit, the system provides the Community Health Volunteers with a means of keeping track of how their households are doing and how their area compares to other neighborhoods. Although the system was not designed to stimulate friendly competition between wards and Community Health Volunteers, it seemed to do so naturally.

STEP (8) Conduct Rigorous Monitoring and Evaluation

While the Health Information Management System is an integral part of Concern's monitoring and evaluation system, there are many other elements that make up the robust monitoring and evaluation plan. This chapter details a number of assessments and surveys that are conducted using participatory techniques, involving the municipal/district health staff, local health committees, and community volunteer network members, including a Knowledge, Practice, and Coverage Survey, Health Facility Assessment, and Health Institution Capacity Assessment Process. Together these tools provide accurate baseline data and track the program's progress on a variety of health and capacity building indicators, allowing all stakeholders to see which aspects of the program are working, and where adjustments are required.

At the heart of Concern's Urban Heath Model's monitoring and evaluation system is the participatory learning and action approach, which ensure that community members are involved in the collection of data and the analysis and discussion of the findings. In this way, the community becomes involved in the process and learns directly the extent and nature of their health problems. The Local Health Committee members and Community Health Volunteers are often more motivated to work hard to improve the health status in the ward once they gain firsthand evidence of the health problems faced by their community.

Knowledge, Practice, and Coverage Survey: A Tool for Tracking Health Knowledge, Behaviors and Services

At the start of the project, a Knowledge, Practice and Coverage survey is carried out. The purpose of the Knowledge, Practice, and Coverage survey is to determine the baseline situation against which subsequent health indicators may be measured; as well as to identify priority areas which required immediate attention as part of the program's planning component. The eight major indicators measured through the Knowledge, Practice and Coverage surveys are:

- Maternal health and nutritional status
- Child nutritional status
- Immunization coverage of children under one
- Knowledge and behavior that reduces the risk of common childhood illness
- Antenatal care coverage
- Safe/hospital deliveries
- Adequate child spacing
- Prevention and early detection of HIV and AIDS

The Knowledge, Practice, and Coverage surveys may be implemented at mid-term and endline to evaluate overall progress. Please refer to the Maternal Child Health Integrated Program (MCHIP) website at **www.mchipngo.net** to access more information on these surveys.

Health Facility Assessment: A Tool for Tracking Quality of Services

Another important monitoring and evaluation tool is the Health Facility Assessment, which focuses on the quality of the services provided at a particular health unit. This instrument collects information on the case management

of childhood illnesses (acute respiratory infection, diarrhea, malaria, measles and malnutrition) and on drug supply, equipment, supervision and training. Typically, exit interviews with patients are also included to ascertain what the patients themselves think about the care they have received and whether the provider gives them the correct messages and prescription information.

The Health Facility Assessment is used as a planning tool for the municipal/district health management and the local health committees. The data is also used to identify gaps in health facility staff performance and quality of care so that strategies can be developed to address these flaws.

Health Institution Capacity Assessment Process (HICAP)

As mentioned throughout the document, capacity building is central to Concern's Urban Health Model. In order to measure progress in capacity building among mid-tiered coordination committees, Concern developed the Health Institution Capacity Assessment Process (HICAP). As described in Chapter 2, the HICAP is a useful tool for orienting municipal authorities and committee members on their roles and responsibilities and measuring how they are performing in various aspects related to the effective running of the program.

The HICAP can also be streamlined for use with local health committees. Because local health committee members may be even less familiar and experienced with how an organization functions, focusing on just a few aspects (i.e. participatory planning, leadership, resource mobilization and management, collaboration and coordination, and monitoring and evaluation) of a smoothly running organization provides the managers and members with important feedback on how they are performing and where they need additional training and support. The process review gives program managers periodic opportunities to reinforce messages from the original local health committee orientation and focus on what the committee must do to improve its performance.

The community-level process monitoring methodology utilizes a five-point scale. As illustrated in Chapter 2, the different points on the scale are referred to in terms of something that the local population can easily relate to, such as the cultivation of a fruit tree. The starting point or lowest level is "seed sowing." The next level is "germinating," which progresses to "sapling," "maturing," and finally "fruit bearing," when the process is completely developed. Every indicator has a description. The HICAP exercise creates a shared understanding of the capacities required for the local health committee to fulfill its purpose and become an effective and lasting institution in the community. At any one time, local health committee members know exactly where they are on the organizational development continuum and what they have to do to advance further. Whatever is required, be it more training or technical assistance, is then made a part of the annual local health committee plans.

Tracking the Poorest

As highlighted in Chapter 2, one of Concern's Urban Health Model's underlying principles is its commitment to reaching the extremely poor and least advantaged groups. If significant improvements are to be made in the most important health indicators, it is essential that the poorest and least healthy segment of the population be reached, as they have the worst knowledge, practices and results. In order to ensure this commitment is fulfilled, however, it must also be tracked. Local health committees should maintain a list of the poorest households in the community, and this list may be incorporated into data analysis to ensure these households are receiving at least the same level of services as others.

It is this special attention and monitoring that accounts for the impressive reduction in the equity gap, referred to in the Chapter 2. It proves the truth in the old saying, "What gets measured, gets done."

STEP ⑨ Ensure Sustainability

The whole premise of Concern's Urban Health Model is based on building municipal/district level capacity and mobilizing the community so that they can enjoy better health status on an ongoing basis. It is thought that once the health awareness of the community has been raised and child health care practices are improved, the organizations that have been developed at the municipal and ward levels should be able to sustain these achievements.

Saidpur and Parbatipur, the first two municipalities in which Concern's Urban Health Model was developed, continued to operate during the scale-up phase, which provided Concern with key insights into how programs would continue to operate with little or no support or supervision. Concern was particularly interested in what happened after the external support completely ended, and what could be done to encourage continued effective health efforts and maintain gains achieved in health indicators.

Concern used this opportunity to conduct a sustainability assessment in 2009, five years after the first phase of the program in Saidpur and Parbatipur was completed. The assessment found that the municipalities were able to maintain basic operations and observed mostly stable values for maternal and child health outcomes. Basic operations and health indicators were maintained (seven coverage indicators were unchanged, three continued to improve more slowly, and two decreased). However, less success was achieved in the governance and strategic guidance of the model by the municipalities. Some weaknesses were also observed in human resource management. Although the reliance on municipal authorities is key to ensuring a sustainable response, Concern's sustainability study identified the following lessons that future implementers should bear in mind:

Lesson 1: Municipal and Local-level Leadership

Municipal and local-level leadership positions are elected and are subject to change with every election. It is very disruptive when the person who is oriented and has led the health effort for years is no longer present. To decrease the negative impact of this leadership shift, Concern's Urban Health Model emphasizes the importance of having a strong and fully oriented alternate or vice-chair in the mid-level leadership team and local health committee. This person can provide leadership when the chair is not present or is no longer in charge. This leads to a smoother transition and handover of leadership to the new chairman, providing ample time for his/her orientation in the program and reducing disruptions in the program, thus minimizing any resulting decline in performance.

Lesson 2: The Importance of the Push Factor

"*We can continue to have meetings. Concern never gave us money, they gave us ideas. However, who will keep pushing us and giving us ideas?*"

– Ward Health Committee Member

Having a local entity that can also "push" the municipal government to do what needs to be done to keep the Urban Health Model functioning is another valuable lesson learned. This "push" refers to a combination of vision, technical assistance and the role of "champion of progress." Someone must demand accountability from all parties involved in the program, from the municipal authorities to the ward officials and volunteers. It is an outside entity,

usually an NGO like Concern, which initiates the program and builds the capacity. The local implementers develop what can be referred to as a "process dependency" on the exogenous group. What happens when they are no longer present? Who is going to ensure that organizing bodies meet regularly? Who will make sure that the new volunteers are trained and refresher trainings are conducted each month?

Concern's experience suggests that it is advisable to have a local, like-minded group that can provide the "push" factor when it is required. Any NGOs that operate in the municipality and expect to continue working there for the long term can serve this purpose of coordination, guidance and motivation. It is essential that this group, which will be around after the program ends be identified, oriented and involved early on in the implementation phase. The local NGO should be familiar with how the Urban Health Model works and with the local leadership in the municipalities and wards long before the external agency withdraws.

Lesson 3: Volunteer Retention

One concern that is raised whenever uncompensated volunteers are involved is their dropout rate and how this affects the sustainability of the program. This has not proved to be a problem in Concern's Urban Health Model: the dropout rate among Community Health Volunteers over 10 years in the nine municipalities was 17.3%, which translates to an annual dropout rate of less than 5%. Among the volunteers that did drop out, the main reasons for doing so included: migration, marriage, education and employment. Ultimately, the dropout rate has not been a major problem for the program, thanks in part to the popularity of volunteer positions and the social recognition gained as a result of volunteering.

However, Concern's Urban Health Model recognizes that volunteer departure is an inevitability, and has developed a way to minimize the impact. When a Community Health Volunteer leaves the program, there is little or no impact since a high proportion of them have "apprentices" who regularly assist the volunteers in their rounds, visiting homes or collecting data. If/when the volunteer has to resign from the position, the apprentice is typically ready, willing and able to assume the job. The new volunteer will receive training, but in the meantime she is immediately able to serve her area since she is already familiar with the households and the content of the program. As a result, there is little or no drop in program operations.

Nor are there any problems with dropouts within the other cadre of volunteers. For example, very few Imams have become inactive: 88% were still serving on their local health committee at the time of the sustainability study. The Community Birth Attendant dropout rate is as low as 6.5%. The lowest dropout rate is among the Private Practitioners: 96% continued to serve on the local health committee at the time of the sustainability assessment.

STEP ⑩ Consider Costs

One of the original motivations for developing the Urban Health Model was the realization that Concern Bangladesh's health service delivery program in the mid-1990s had the highest cost per beneficiary of any Concern health program around the world. Concern was forced to come up with a new, less expensive approach to obtaining the same level of quality care, ideally with a more significant net beneficiary impact.

Consequently, Concern's Urban Health Model was specifically designed to focus on capacity building and facilitation, rather than on direct service provision. Costs were minimized by not constructing facilities or providing hardware, such as vehicles and equipment/supplies. And there was no financial investment in hiring staff to deliver services. Instead, an emphasis was placed on building a strong human foundation – by tapping into what human resources were available - and reviving a municipal structure that would ultimately improve local services and health outcomes.

What makes Concern's Urban Health Model so effective, as well as so inexpensive to establish and sustain, is the fact that it adds no material benefit to the existing municipal and health structures. Funds are used to innovatively tap into and develop existing human resources; revive nacent, but existing, organizing bodies; and ultimately establish streamlined and responsive organizations at the municipal and ward levels that are capable to serving the health needs of all members of the community.

In fact, the primary costs involved in replicating Concern's Urban Health Model are associated with advocacy and training of Municipal Health Department staff and a large number of local health committee and community members. These are people who already live in or work with these communities and who will ensure the continuation of the program even after the external organization has withdrawn. Chart below illustrates how funds were spent.

What's the Bottom Line?

- During the first phase, from 1999 - 2004 with just Saidpur and Parbatipur, total cost per beneficiary per year was $5.46
- During the second phase, from 2005 - 2009 when the program scaled up to seven additional municipalities, the total cost per beneficiary per year decreased to $2.45 per beneficiary per year
- Overall, over the decade of programming in Bangladesh, the total cost of the program averaged at $3.95 per beneficiary per year.

- **Monitoring and Evaluation**
- **Strengthen Municipal Health Department**
- **Community Networks**
- **Ward Health Committee Formation**
- **Advocacy with Municipality**

Costs for the Municipality

Concern's Urban Health Model expects the municipality to assume some of the costs of sustaining the program as a part of its normal operating costs. Many of the costs are already covered in their existing budget, including the cost of supporting district/municipal management team operations and the salaries of the health department staff. The supervision of the local health committees, as well as the volunteers, is included in the job descriptions of the Municipal Health Department staff. The remainder of staff at the ward level are volunteers and do not receive compensation.

Therefore, the costs that the municipalities are expected to cover are minimal, and include the cost of volunteer refresher training at monthly meetings and special health events once or twice a year (e.g. World Health and Safe Motherhood Days). Not only do these celebrations reinforce important health messages, they also help remind people that health is a critical issue for the community. Luckily, the costs associated with these activities are relatively small and with all the extra attention given to health issues under the project, municipal budgets allocated to health tend to increase, sometimes doubling or even tripling (albeit from a very small base), as was the case in Northern Bangladesh.

It is possible for municipalities to levy taxes and some of the municipalities involved in Concern's Urban Health Model in Bangladesh have done so in order to support and maintain their improved health systems.

CHAPTER 4

CONCLUSION

The Urban Health Model proposes a mechanism for an implementing agency to serve as a catalyst within a community for a limited period of time introducing knowledge and changes in the health and civil society structures and processes. This mode of delivery improves health providers' practices, increases the community's health awareness, and alters health behaviors, all of which result in significantly better health status among mothers and children.

Such changes can be sustained even in poor communities because they do not depend on the influx of outside resources – physical or financial.

Changes are achieved as a result of the core strategies employed to introduce change.
These strategies include:

- Building managerial and technical capacity
- Mobilizing communities

- Encouraging networking among the principal health services providers, health professionals and workers, civil authorities, and community leaders

By utilizing only people within the community, all of whom work entirely on a voluntary basis, no increased recurrent costs have been left behind to burden cash-strapped municipalities.

Concern's Municipal Health Program in Northern Bangladesh was implemented with few requirements for tangible goods, resulting in a program that had a relatively low cost per beneficiary served. In **developing technical capabilities** at the municipal and ward levels and **capitalizing on existing local resources**, the program lays a strong foundation for sustaining the interventions and establishing a lasting tripartite partnership (between the municipal government, private health sector and local community) with the shared goal of improving the health status of the community through their own efforts.

The Urban Health Model offers a chance to achieve ***high impact, long-term, low-cost improvements*** in the health status of urban populations in Bangladesh and throughout the globe. Organizations and agencies focusing on urban health, including donor groups, should consider how this model can help them achieve Millennium Development Goals 4 and 5 (reduced maternal and infant/child mortality and morbidity) among the poorest segments of urban and peri-urban populations in Bangladesh and in other developing countries facing similar health challenges associated with rapid, unplanned urbanization.

Concern has developed, tested and replicated a model for improving health within the urban context. The Bangladesh experience demonstrated that the Urban Health Model is effective at improving access to health information and services, and the model is scalable, equitable-reaching the poorest and most vulnerable, and sustainable. Furthermore, Concern expanded the geographic focus beyond Bangladesh and adapted concepts, principals and lessons learned from the urban health model to another child survival program in five urban slums of Port-au-Prince, Haiti. Immediately following the 2010 earthquake, youth volunteers rapidly responded to mobilize the communities and support Concern's emergency response efforts. The urban health model provided a platform to gather community actors and improve social cohesion in communities that were traditionally neglected and fragile. Most recently, Concern has proposed adopting the Urban Health Model in the African context as best practice for effectively reaching and improving health outcomes in urban slum communities.

Rates of urbanization will continue increase indefinitely and unforeseen disasters are imminent. Of particular concern, is rapid, unplanned urbanization in least developed countries that lack sufficient infrastructure to accommodate expanding urban communities, Approaches such as the Urban Health Model may be implemented to mitigate poor health outcomes and encourage community cohesion and responsibility for health, ultimately saving the lives of thousands of women and children.

Notes

New York

355 Lexington Avenue, 19th Floor, New York, NY 10017

Phone: (212)-557-8000

Fax: (212)-557-8004

Chicago

332 South Michigan Avenue, Suite 630, Chicago, IL 60604

Phone: (312)-431-8400

Fax: (312)-431-8830

info.usa@concern.net

www.concernusa.org