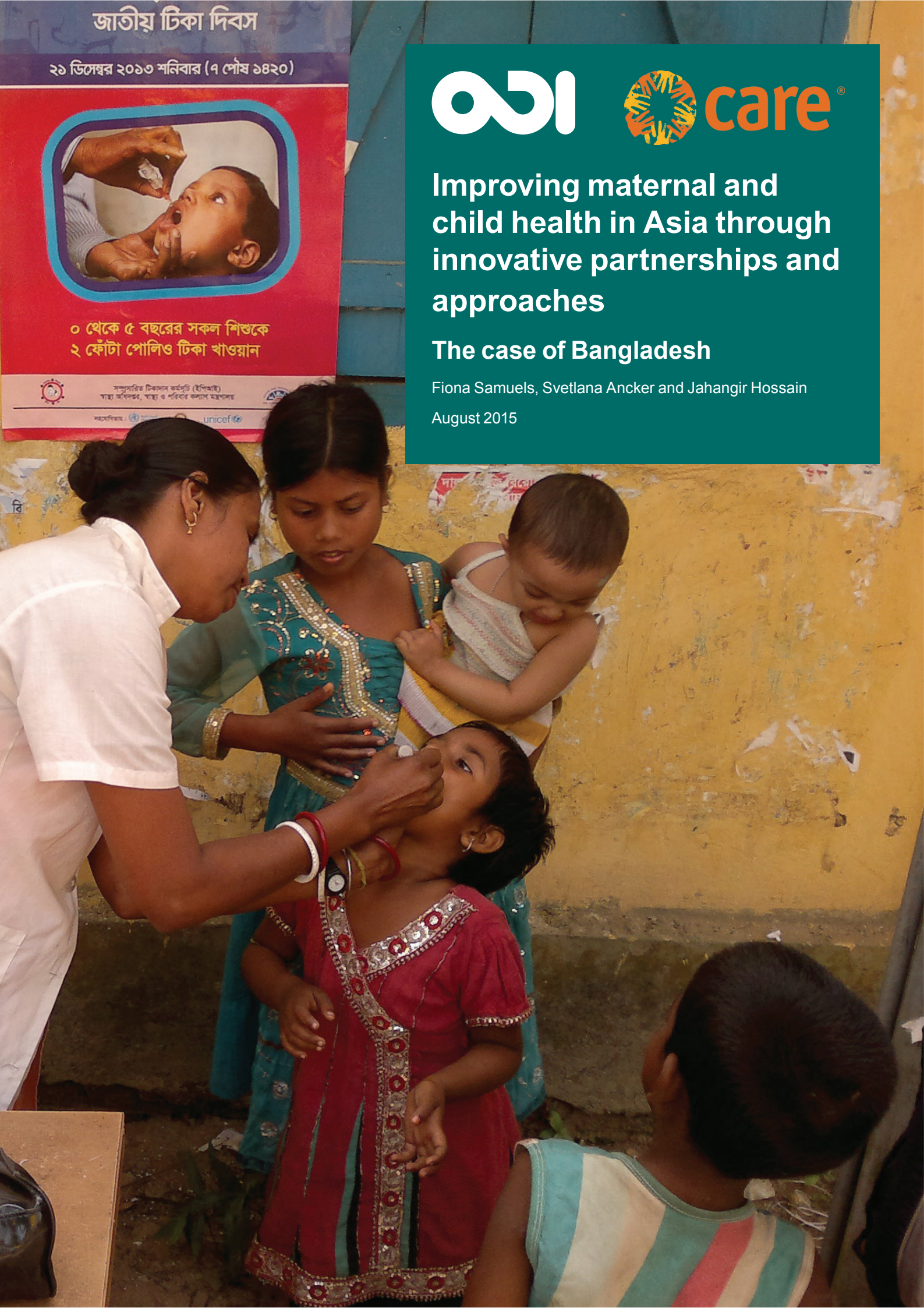

Improving maternal and child health in Asia through innovative partnerships and approaches

The case of Bangladesh

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Abbreviations

ANC	Antenatal care
CEmOC	Comprehensive emergency obstetric care
CHCP	Community health care provider
CHV	Community health volunteer
CHW	Community health worker
C-IMCI	Community based- integrated management of childhood illnesses
CmSS	Community support system
ELCO	Eligible couples for family planning
ENC	Essential newborn care
ESP	Essential services package
FP	Family planning
FWA	Family welfare assistant
FWV	Family welfare visitor
GoB	Government of Bangladesh
GSK	GlaxoSmithKline
HA	Health assistant
HW	Health worker
MIS	Management information system
MMR	Maternal mortality ratio
MNCH	Maternal and neonatal child health
MOHFW	Ministry of health and family welfare
OGSB	Obstetrical and gynaecological society of Bangladesh
P-CSBA	Private community-based skilled birth attendant
PHC	Primary health care
PNC	Post natal care
PPP	Public-private partnership
SBA	Skilled birth attendant
TAG	Technical advisory group
TBA	Traditional birth attendant
TFR	Total fertility rate
UHC	Upazila health complex
UH&FPO	Upazila health and family planning officer
UH&FWC	Union health and family welfare center
UNFPA	United nations population fund
UNICEF	United nations children's fund
UP	Union parishad
WHO	World health organization

This briefing is the second of a series of three that summarise key processes and outcomes emerging from an innovative partnership between CARE International UK and GlaxoSmithKline (GSK) to improve maternal and child health in six Asian countries: Afghanistan, Bangladesh, Cambodia, Laos, Myanmar and Nepal. The partnership focuses on increasing the effectiveness and capacity of frontline health workers (HWs), strengthening health systems and enhancing community mobilisation. This briefing focuses on the CARE-GSK Community Health Worker (CHW) Initiative, a public-private partnership approach to strengthen community health systems so that they can, in turn, improve access to services for mother and children in remote communities in Bangladesh. The project will complete its first three-year phase in November 2015 and there are plans for a second project phase starting in 2015 and running until 2018. CARE International has been working in Bangladesh for 65 years to empower women, support the poorest people to improve their own health, food security and economic opportunities, and facilitate social transformation.

Following an overview of maternal and neonatal child health in Bangladesh and in the Sunamganj district covered by the project, the briefing outlines the background to the project itself. It then describes its goals and objectives and main achievements to date. The remainder of the briefing describes the innovative tools and mechanisms that have been used by the project to improve maternal and neonatal child health in remote and marginalised areas of Bangladesh. The briefing concludes with some lessons learned and recommendations for the future.

1 Overview of maternal and neonatal child health in Bangladesh and in project districts

Bangladesh has been able to reduce its maternal mortality ratio (MMR) from 340 to 170 maternal deaths for every 100,000 live births from 2000 to 2014 (World Bank, 2014). Despite this achievement, only 37.4% of deliveries occur in health facilities and only 42.1% of births are attended by a medically trained provider. Some 37.5% of births are still attended by untrained providers and only 23% of women with complications receive Comprehensive Emergency Obstetric Care (CEmOC) services, with large discrepancies in the use of these services between the urban (38%) and rural areas (18%) (BDHS, 2014). Table 1 summarises key health indicators related to maternal, neonatal and child health in Bangladesh.

Table 1: Key maternal, neonatal and child health indicators in Bangladesh

Indicators	National	Rural
Family planning*		
Total fertility rate	2.3	2.4
Contraceptive prevalence rate (modern methods)	54.1%	53.2%
Unmet need for family planning	12%	12.9%
Maternal health**		
Maternal mortality ratio (per 100,000 live births)	170	N/A
% deliveries by medically trained personnel	42.1%	35.6%
% deliveries in health facility	37.4%	30.6%
% deliveries by untrained traditional birth attendants	37.5%	41.8%
% women who get four antenatal care visits	31.2%	26.1%
% women who get a post-natal care visit by a qualified provider within 48 hours of delivery	34%	N/A
Child health**		
Under-five mortality ratio (per 1,000 live births)	46	N/A
Infant mortality ratio (per 1,000 live births)	38	N/A
Neonatal mortality ratio (per 1,000 live births)	28	N/A
% of newborns breastfed within the first hour	57.2%	57.7%
% of newborns bathing delayed to 72 hours after birth	34.4%	35.3%
% children with acute respiratory infection for whom treatment is sought from a qualified health provider	42%	39.3%

*Source: * BDHS, 2014; **World Bank, 2014.*

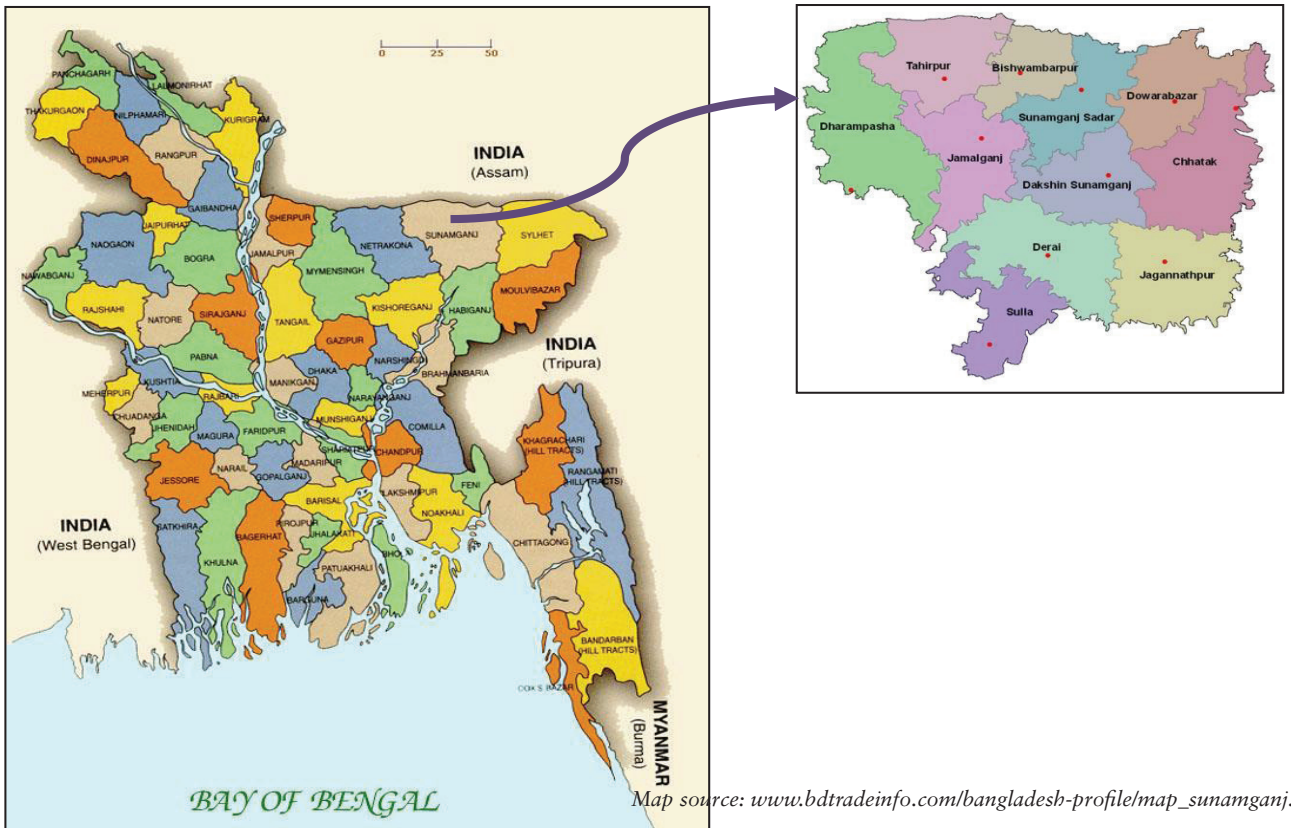
The picture of maternal and neonatal child health in Bangladesh is a mixture of success and disparities. While Bangladesh reduced its total fertility rate (TFR) to 2.3 children per woman in 2014, the TFR is still higher in rural areas, at 2.4 children. While more than half of the population uses a modern family planning (FP) method, around 12% of the population still has an unmet need for FP. Bangladesh has also reduced child and infant mortality through effective immunisation, the control of diarrhoeal diseases and the treatment of acute respiratory infections – all facilitated by improvements in health-seeking behaviours, with people increasingly likely to use health services.

In contrast, there has been little progress on the neonatal mortality rate, which still stands at 28 deaths for every 1,000 live births – almost half of the total child mortality. Newborn deaths are linked closely to the management of births and their reduction requires very different strategies, particularly because most deaths occur at home, where many women still deliver their children and where they are often attended by unskilled care providers. Traditional practices also contribute to newborn deaths. For example, only 57.2% of newborns are breastfed within one hour of their birth, as recommended by the World Health Organization (WHO). Lastly, only one third of those caring for newborn babies seek services from a health facility or a skilled care provider.

In rural areas, the Ministry of Health and Family Welfare (MOHFW) is responsible for the provision of all levels of health services offered as part of the Essential Services Package (ESP). Primary health care (PHC) services are provided through a network of field workers namely Family Welfare Assistants (FWAs) and Health Assistants (HAs). These field workers also support the Family Welfare Visitors (FWVs), based at the Union[1] Health and Family Welfare Center (UH&FWC), in the organisation of satellite clinics. The MOHFW has already established 13,500 community clinics that are staffed with Community Health Care Providers (CHCPs), each of whom have had 36 days of PHC training. Secondary and tertiary services are provided through Upazila[2] Health Complexes (UHC) and district hospitals as well as range of private providers.

While the MOHFW health infrastructure exists in most areas, there is a major shortage of qualified health providers. WHO recommends 2.3 health providers for every 1,000 people, but Bangladesh has just 1 provider for every 1,000. Geographical barriers in remote rural

Figure 1: Map of Bangladesh and project district of Sunamganj



Map source: www.bdtradeinfo.com/bangladesh-profile/map_sunamganj.jpg

1 A Union is the smallest rural administrative and local government unit in Bangladesh.

2 The *upazilas* are the second lowest tier of regional administration in Bangladesh; they function as sub-units of districts.

areas mean that absenteeism is rife and it is difficult to retain qualified health providers; additionally, inadequate supervision and monitoring and limited transparency are commonplace. As a result, around 62% of births take place at home, and they are often conducted by unskilled providers (BDHS, 2014). In addition, most skilled health-care providers live in towns and cities, leaving high vacancy rates in rural and remote areas. Bangladesh now has a surplus of untrained providers, with 1.3 for every 1,000 people, which means that many people are spending a lot of money for medical services that are of poor quality or even harmful (Bangladesh Health Watch, 2008).

Sunamganj (see Figure 1 for its location within Bangladesh) was selected as the project district for the CARE-GSK Community Health Worker (CHW) Initiative for three reasons:

- it is an underserved remote *haor*[3] area that has poor maternal, newborn, and child health indicators when compared to the national averages (see Table 2)
- it is a priority district for the Government of Bangladesh (GoB)
- it has the potential for collaboration and synergies with other development projects.

Table 2 provides an overview of key health indicators in Sunamganj District, comparing to the 2010-2012 national averages, while Table 3 sets out the district populations and project beneficiaries.

Table 2: Particular vulnerabilities in Sunamganj District

Indicator	Sunamganj	National
Maternal mortality ratio	424/100,000 live births (BMMHCS, 2010)	194/100,000 live births (BMMHCS, 2010)
Under-five mortality rate	87/1,000 live births*	53/1,000 live births*
Use of modern contraceptive methods	45%*	52%*
Delivery by skilled providers	11.2%*	32%*

**Project baseline data (CARE Bangladesh, 2012)*

1.1 Overview of the GSK 20% Reinvestment Initiative and the CARE-GSK partnership

To help respond to a shortage of 7 million health workers worldwide and a growing overall burden of disease, CARE International UK has entered into partnership with GlaxoSmithKline (GSK) as the implementing partner of GSK's 20% Reinvestment Initiative in Asia. This corporate community investment initiative aims to reinvest 20% of company's profits into strengthening of community health systems in a number of least-developed countries where GSK operates. This strategic partnership between CARE and GSK focuses on improving maternal and neonatal child health by improving the quantity and quality of frontline community health workers in the most remote and marginalised communities in six Asian countries: Afghanistan, Bangladesh, Cambodia, Laos, Myanmar and Nepal. Through a mix of programming, lesson-learning and advocacy efforts, the initiative hopes to galvanise further national and international action on the health workforce issue. The CARE-GSK partnership is about to complete its first phase (2011-2015) and plans to continue and scale up its projects in 2015-2020.

1.2 Project overview of the Community Health Worker (CHW) Initiative

To address the shortage of qualified health workers in remote communities, the project is strengthening community health systems in 50 unions of Sunamganj district through a public-private partnership. The goal of the project is to improve the health of women and children in these remote communities by improving access to health services. The project is targeting 1.4 million people and its original aims were to:

- train 150 skilled CHWs
- build the capacity of community groups
- establish community-led accountability mechanisms
- leverage lessons learned to improve maternal, neonatal and child health (MNCH) outcomes in remote, underserved and poor communities
- strengthen relationships with local government at the union and Upazila levels, as well as with the overall health system.

The specific objectives were to:

- enhance community efforts to create local solutions that improve MNCH outcomes
- create sustainable health providers that can offer affordable and high quality MNCH services in remote communities
- enhance the effectiveness of community-led support and accountability mechanisms
- leverage lessons learned to improve MNCH health outcomes for remote communities in Bangladesh.

3 A *haor* is a wetland ecosystem in the north eastern part of Bangladesh which is a bowl- or saucer-shaped shallow depression, also known as a backswamp.

1.3 Overall project achievements

Training of CHWs

- 168 P-CSBAs (Private Community-based Skilled Birth Attendant) have graduated and are now providing maternal and child health services in 150 remote wards of Sunamganj. The P-CSBAs received six months of training on Community Based Skilled Birth Attendance, Primary Healthcare and Community based-Integrated Management of Childhood Illnesses (C-IMCI), and training on social entrepreneurship.
- P-CSBAs provided 138,946 skilled health services up to June 2015: 8,918 deliveries; 79,552 ante-natal care (ANC) visits; 38,785 post-natal care (PNC) visits; 11,691 child-related services; and referred 2,560 women and children to health facilities.
- 2,112 Community Health Volunteers (CHVs) were trained on pregnancy registration, birth preparedness, essential newborn care (ENC), family planning, essential health service promotion and referral. On average, 12 CHWs were identified and trained in every catchment area of each P-CSBA. These CHWs are now responsible for pregnancy registration, birth planning, and health promotion and linking families with P-CSBAs for skilled maternal health services.
- 1,050 public health-service providers and workers were trained in community-based birth attendance, training of trainers (TOT) on IMCI, supportive supervision of P-CSBAs, performance monitoring and data-based decision-making.
- 185 Community Support Systems (CmSSs) were established and are now functioning, and the capacity of their 3,100 CHVs has been enhanced so that they can identify and address barriers to health service access, especially for poor families, and create an enabling environment for P-CSBAs to perform effectively.
- There has been engagement with 50 Union *Parishads* (UP) (local government bodies) and 700 local-government elected members have been trained on their roles and responsibilities in improving maternal and child health in their respective constituencies, such as allocating resources for the emergency referral of poor families, providing logistic and transport support to ensure P-CSBAs' timely service provision and referral to appropriate health facilities.

Infrastructure

- 10 skill laboratories have been established in the government hospitals of Sunamganj. These laboratories are well equipped training rooms at sub-district hospitals, where different models and flow-charts for delivery and newborn care provide hands-on and needs-based refresher training for P-CSBAs. The MOHFW health providers and medical doctors provide periodic training using these laboratories.

Awareness-raising

- By June 2015, 181 folk-song sessions had been organised to introduce and promote P-CSBA services and to address MNCH issues in the project communities.
- 7,250 courtyard sessions were held to promote P-CSBAs and their services and raise awareness of the services offered by skilled MNCH providers.
- 25,616 birth planning sessions were conducted since 2012.

Table 3: Project district and number of targeted beneficiaries

Indicator	Sunamganj
Total population (BBS, 2012)	2,467,968
Total number of target upazilas	10 (5 unions per upazila)
Population in the selected 50 unions in the district	1,386,660
Direct beneficiaries in the selected project areas	
Women of reproductive age (15-49 years)	355,475
Eligible couples for family planning	106,642
Pregnant women/ per year	43,667
Children under two years of age	79,861
Direct Beneficiaries	488,657

Source: CARE Bangladesh project data

Advocacy

- A biannual Technical Advisory Group (TAG) was established and two meetings were held with key national and international partners.
- Five issues of a bi-annual Newsletter were published, outlining project progress, findings and learning.
- The quantitative and qualitative parts of a baseline study were published and disseminated through workshops at national and district level.
- A National Round Table on 'Human Resources for Health: Foundation for Universal Health Coverage and the Post-2015 Development Agenda' was organised.
- Together with the government, a number of health-related informational and advocacy activities were organised, such as rallies, health education sessions, health camps, and campaigns for key days, including World Health Day, Safe Motherhood Day, the Measles-Rubella Campaign and 21 National Immunisation Days.

Beneficiaries

- A total of 367,186 direct beneficiaries, including mothers and children, were reached from 2012 to 2015.
- A total of 1,101,558 family members and community members have benefited indirectly from project activities.

2 Innovative tools and processes

This section focuses on four major innovations of the project: 1) the establishment of a cadre of Private Community-Based Skilled Birth Attendants (P-CSBAs); 2) setting up the Community Support Systems (CmSSs); 3) promoting Social Entrepreneurship; and 4) developing the Private-Public Partnership model.

2.1 Private Community-Based Skilled Birth Attendants (P-CSBAs)

Skilled attendance at birth is one of the most effective ways to prevent maternal and newborn mortality. One key mechanism to address the second key objective of the project (*Create sustainable health providers that can offer affordable and high quality MNCH services in remote communities)* – is through the P-CSBAs. This process was developed in collaboration with the MOHFW to support service delivery at community level and, in particular, to reach and cover remote and underserved areas[4].

As a result of this project, each ward in Sunamganj district now has at least one P-CSBA, who is supported by and linked to the Community Support Group (see section 2.2), other community structures and the broader health system. P-CSBAs provide critical care at the community level, including skilled home delivery, ante- and post-natal care and essential newborn care, and serve as an important link to the formal health system by referring complicated cases to health facilities.The uniqueness of the P-CSBA model lies in the fact that they have been trained not only to provide skilled maternal health care in rural areas, but also in financial and managerial skills. With a high attrition rate for CHWs, the project has focused on ensuring the long-term financial sustainability and income-generation capacity of its P-CSBAs.

P-CSBA selection, training and introduction to the community process

The stages for the selection and training of the P-CSBAs are as follows:

- The project team, together with key stakeholders and partners, maps all health providers and services in the area to identify any shortfalls.
- The community and the UP are closely involved in the selection of women for P-CSBA training. These women also need to meet a number of criteria, including having an education up to Grade 10, being willing to stay and serve their community after their training, and being willing to:
  - provide maternal and neonatal child health (MNCH) services, including at night, and to refer cases they cannot handle
  - report to and be supervised by the Community Support System (CmSS), UP and MOHFW health system
  - collect data on pregnant women, eligible couples for family planning (ELCO) and children under two years of age
  - negotiate prices for their services, in consultation with the community
  - stay and provide services to the community from which they are selected and where they live.
- The community and the broader health system staff in the relevant areas are then informed about the P-CSBAs and their roles upon completion of the training, and negotiate prices for their services.
- P-CSBAs are then introduced into communities by the UP through a formal local ceremony. During this ceremony UP representatives determine a fee for each service which includes: developing safety net mechanisms for poor families in consultation with the community, CmSS and P-CSBA; announcing these fees publicly; and distributing an approved list of the fees. With the support of local government, services provided by the P-CSBAs have been priced in all 150 unions for 168 P-CSBAs. The project has developed service-pricing guidelines and the pricing process has been operating since December 2013.
- Individual P-CSBAs are introduced to the community and the CmSS that exists in all working unions through folk songs. Folk-song sessions are conducted for each graduated P-CSBA. This helps to inform communities about the importance, training, skills and availability of the P-CSBAs, their links to formal and public health providers and their ability to refer cases.

The P-CSBAs receive two broad types of training: clinical/practical and business training (see section 2.3). Clinical/practical training includes the prescribed six months of training at the Obstetrical and Gynaecological

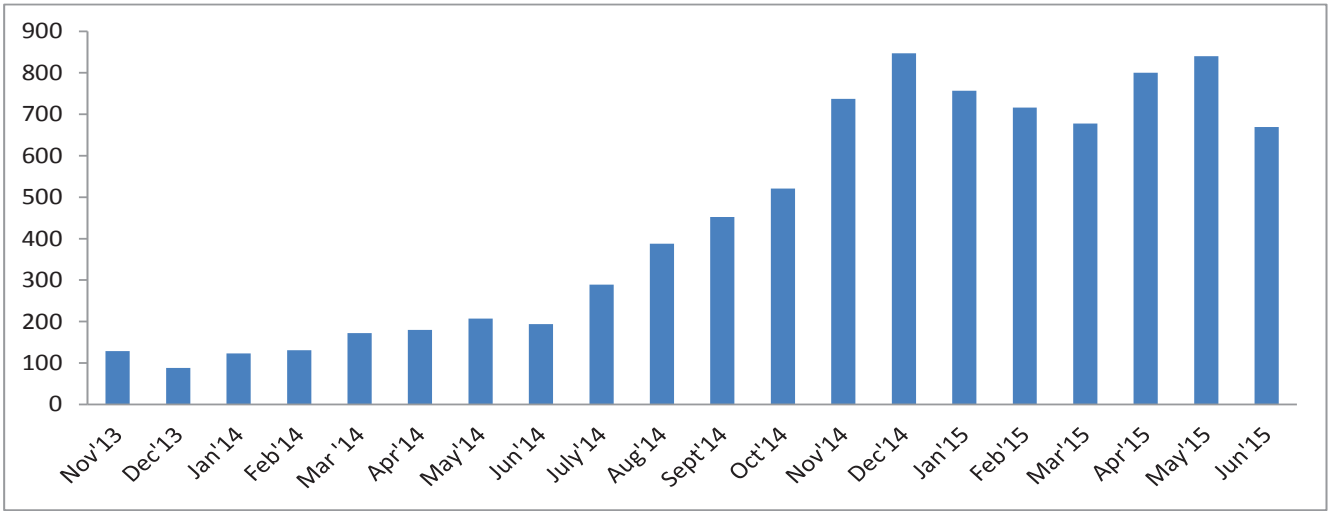
4 The MOHFW is also upgrading the skills of Family Welfare Assistants (FWAs) and Female Health Assistants (HAs) so that they can become CSBAs; such cadres, based in the community, represent the first port-of-call for community members seeking health services.

Society of Bangladesh (OGSB) accredited training institute at district level. Upon completion of their training and once they have passed their final exam, these trainees are accredited by the Bangladesh Nursing Council, enabling them to continue to practice after the completion of the project. CARE organises additional training using existing MOHFW trainers including five-day competency-based training on FP and five-day training on C-IMCI. The P-CSBAs also receive periodic refresher training at their practice sites (both technical and related to business management).

The P-CSBAs are regularly coached and supported by CARE's technical trainer (a nurse) who continues to provide on-the-job training and support to the P-CSBAs once they are accredited for 6-9 months, while building the capacity of the local MOHFW health provider – the Family Welfare Visitor (FWV) – to ultimately take over the supervision of the P-CSBAs. The aims is, therefore, to ensure that the P-CSBA provider becomes part of the system at community level after their training, reporting to the CmSS, the UP and the relevant official in the MOHFW.

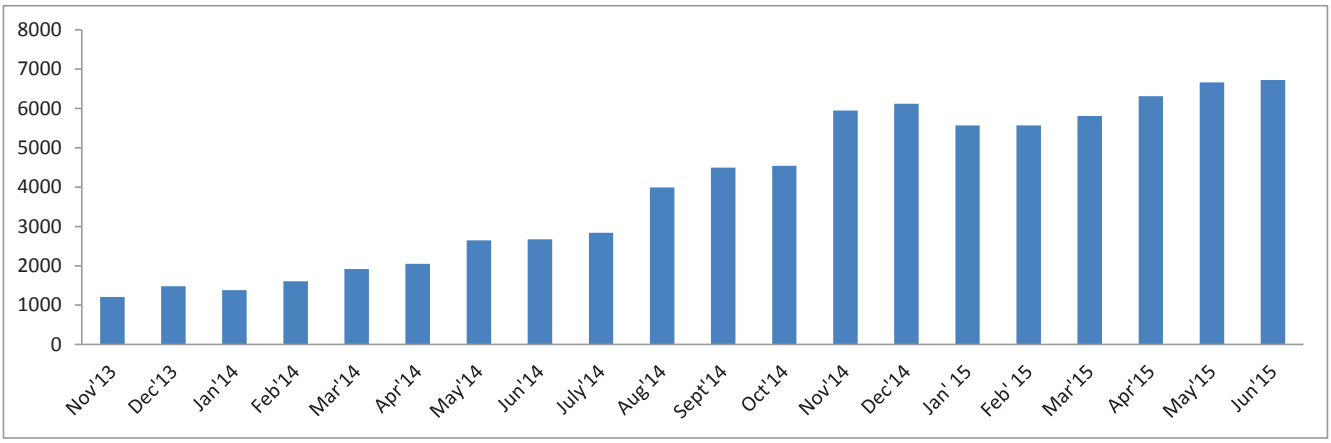
In this model, the P-CSBAs continue to improve their skills and knowledge through continuous assessment by the Training Institute, as well as refresher trainings, close supervision by the project team and local health authorities, such as the Upazila Health and Family Planning Officer and FWV, and through monthly meetings and reporting to CmSS, UP and health workers. They also receive a kit with a weighing scale, stethoscope, measuring tape, blood-pressure monitor and key medications such as misoprostol, oxytocin, clorhexidine, magnesium sulphate, antibiotics, FP supplies and medicines to treat childhood illnesses. Each of the P-CSBAs has a sign to list their services and pricing. To ensure that the business can be sustained, the P-CSBAs receive a monthly stipend of BDT 2,500 (around £20) for nine months after their graduation

Figure 2: Births attended by P-CSBAs per month



Source: CARE Bangladesh project data

Figure 3: Ante-natal care visits by P-CSBAs per month



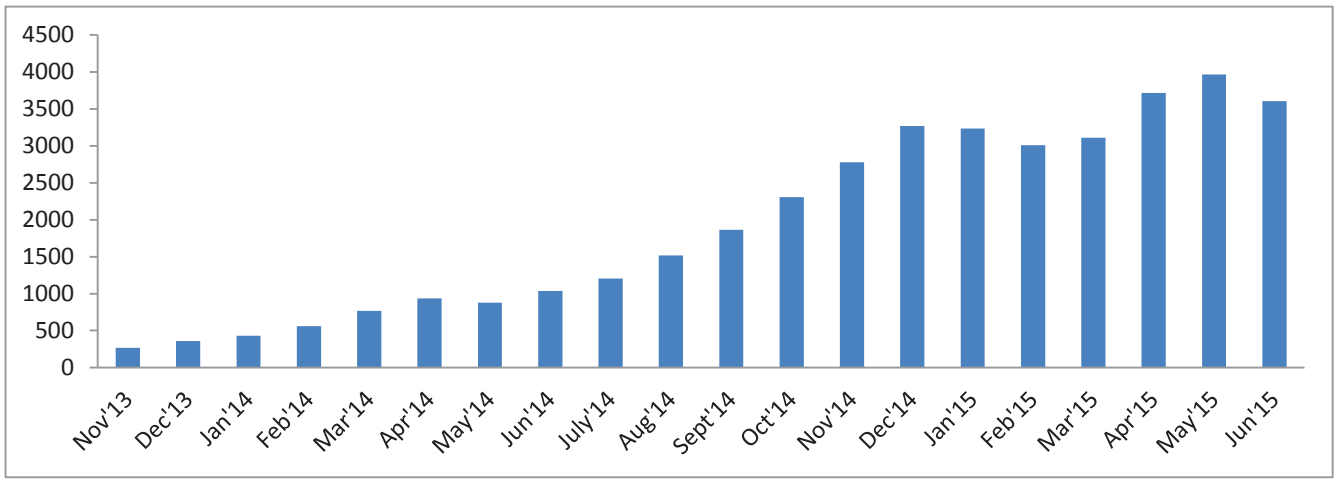
Source: CARE Bangladesh project data

to jump-start their business. This allowed them time to build demand for their services and to negotiate their support for the CmSS and/or UP.

Achievements

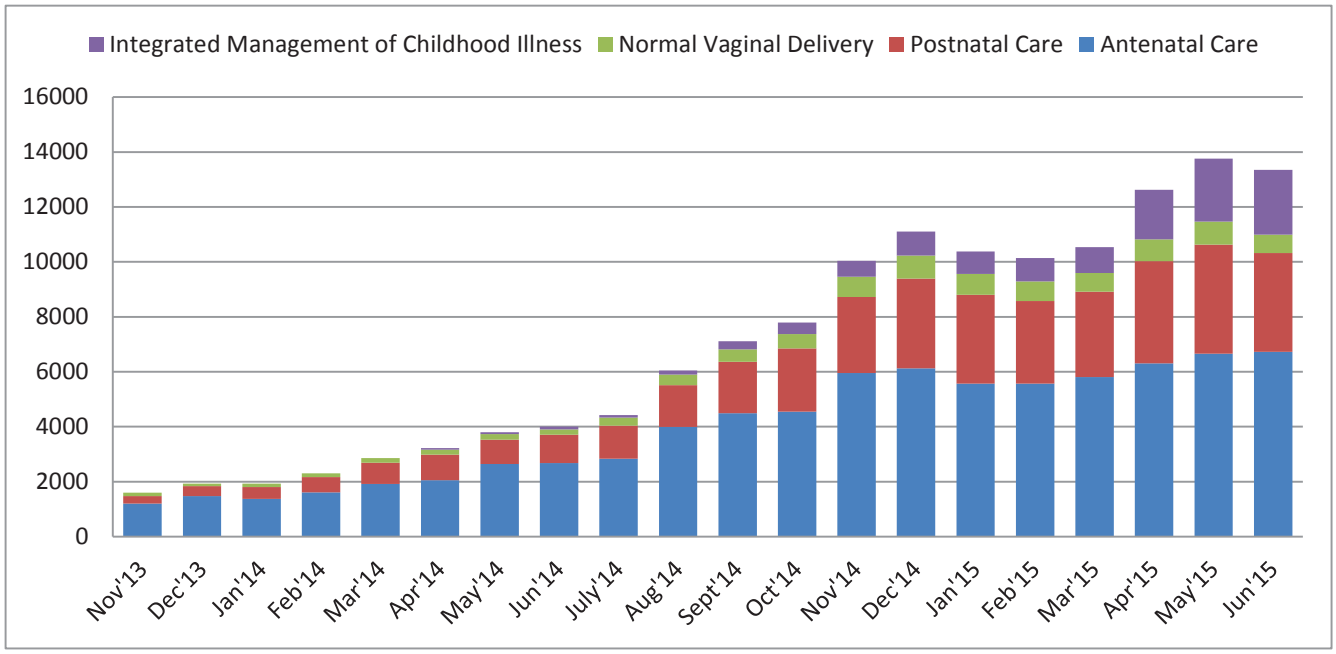
As mentioned, a total of 168 P-CSBAs were trained in batches in 2013-2014. According to project monitoring data and the government Management Information System (MIS), the multipronged efforts of the initiative resulted in an almost four-fold increase in skilled attendance at births between 2011 and the end of 2014, rising from 12% to 49% (Figure 2). P-CSBAs are now registering almost all pregnancies in their catchment areas and providing at least one skilled ANC visit to 99% of registered pregnant women, boosting the percentage of women receiving a skilled ANC visit from 43% to 98% in the project area (Figure 3). Similarly, PNC coverage increased from 8% in 2011 to 45% by December 2014 (Figure 4). On average, each P-CSBA conducted 4.5 deliveries between July 2014 and June 2015, and provided 38 ANC and 20 PNC services. Overall there is a positive trend in the uptake of all P-CSBA services (Figure 5), with some seasonal variation.

Figure 4: Post-natal care visits by P-CSBAs per month



Source: CARE Bangladesh project data

Figure 5: Service delivery by P-CSBAs per month



Source: CARE Bangladesh project data

2.2 The Community Support System (CmSS)

The Community Support System (CmSS) is a mechanism to establish a system at the community level to track pregnant women, and provide support as and when needed. Originally, the CmSS was developed by CARE Bangladesh in 1999 to facilitate local-level planning, track pregnant women and their newborns, build support systems for timely referrals to health facilities and establish accountability mechanisms. Since 1999 this approach has been recognised by both the GoB and the international community and has become a core model for the mobilisation of communities to access skilled delivery-attendance services and emergency obstetric care. This approach has been a core component of the CARE-GSK Community Health Worker (CHW) Initiative and is used to enhance community mobilisation.

Each CmSS consists of at least 17 members, including both men and women, as well as members of poor and marginalised populations. CmSS are supposed to meet on a regular monthly basis. Their role is to support and promote the P-CSBAs in the community, raise community awareness of MNCH good practices and available services, enhance decision-making at the household level, develop communication with local government, advocate on collective MNCH needs, raise funds for emergency transport as part of the referral of complicated pregnancies to formal health services, and lead community accountability for the P-CSBAs.

The key elements and functions of a CmSS are:

- the identification and tracking of pregnant women
- the promotion of birth planning by targeting pregnant women and household decision-makers
- proactive encouragement and support for women and their newborns on the timely use of ANC, SBA (skilled birth attendant), PNC, and ENC services
- proactive support for women with obstetric complications for emergency referral through the mobilisation of emergency funds and the transportation system
- the establishment of a consistent mechanism to share information on MNCH with the health system and local government, and to take evidence-based decisions.

The process of setting up and running a CmSS

- The CmSSs were established using a three-pronged approach:
  - involving communities from the first stages of analysis at the village level and engaging pregnant women and their relatives, as well as caregivers, in community dialogue
  - working with the local government and including this model in local policies geared towards meeting the Health for All strategy and the Millennium Development Goals, as well as building the responsiveness of the local health system to the needs of the community
  - building the capacity of the community to create wider awareness and active participation in the development of local solutions to reduce maternal and child mortality and reinforce accountability.
- At the outset, each CmSS defined the catchment areas, mapped households and developed an action plan for complete surveillance to identify households that include poor, pregnant women, ELCOs, and children so that high coverage and equity can be achieved.
- CmSSs met on a monthly basis to review and analyse performance data on the P-CSBAs, review progress against their action plan and identify remaining needs and priorities that require local solutions. When those needs could not be met by the communities themselves, CmSSs raised the issue at the UP. CmSSs pooled resources through members' contributions, especially those from a higher socio-economic background.
- A workshop was held to discussed referral linkages, attended by CmSS and public and private MNCH service providers. The responsibilities of CmSS in service referral were discussed and a project-specific referral slip was introduced for the referral of women and children in emergency cases. There was an expectation that public and private health facilities would give adequate attention to cases that are referred by CmSSs.
- In order to make public health services more responsive, the CmSS members collected feedback each month from women and children, who had been referred to health facilities, on the quality of health care they have received, and shared this feedback with the UP Chair, as well as with GoB health and FP managers at sub-district coordination meetings, which are also attended by all line-ministry representatives.

Achievements

Through this project 185 CmSSs were established and are currently functioning with fully developed action plans and monthly meetings. A total of BDT 1,704,706 (£14,570) was generated by the CmSSs across the project site and BDT 161,340 (£1,379) was used to provide financial support to 6,278 poor women and children, allowing them to receive skilled health services and referrals. The CmSSs provided support for subsidised transportation to P-CSBAs in 233 cases; provided logistical support, such as signs, bunting and visiting cards, to P-CSBAs in 304 cases; set up 471 satellite clinics; accompanied P-CSBAs for 185 deliveries at night; were involved in 1,350 birth-planning sessions; referred 237 cases and paid P-CSBAs for providing health services to 648 poor women and children.

As a result of CmSS advocacy and participation: 50 UPs allocated an annual budget of BDT 2,715,000 (£23,205) and spent BDT 1,097,700 (£9,382) on: providing health services for the poor, TBA orientation to reduce harmful practices,

organizing blood donations at health camps and referrals, and constructing labour rooms for P-CSBAs at their homes.

The impact of CmSS was summarised by an external qualitative reviewer as follows (CARE Bangladesh, 2011):

- an effective approach for creating a supportive environment for women in the community
- enables poor and marginalised women the timely use of emergency obstetric care services
- provides a collective voice for the community to make the service providers accountable
- creates peer pressure to prevent harmful practices by traditional healers
- addresses broader social and women's issues such as violence against women, early marriage and dowry
- links the home and the health facility by addressing barriers (such as lack of information and finance) that lie between women (especially the poorest) and the health facility.

2.3 Social entrepreneurship

Given the importance of the long-term financial sustainably of the P-CSBAs, the project developed a training and support mechanism, offering selected P-CSBAs necessary business knowledge and skills. This also included support for market and community linkages; and business development, branding and marketing services; as well as monitoring and guidance from various stakeholders involved in the project.

JITA (a sister social enterprise organisation of CARE Bangladesh)[5] has provided support for the P-CSBAs. Staff from JITA have, for example, organised a three-day business training course for P-CSBAs, during which they learned how to develop a business plan; diversify revenue streams (e.g. UPs have reimbursed them for providing service to poor and ultra-poor people); secure a reliable procurement source for medicines/supplies; carry out inventory management; undertake day-to-day accounting; and negotiate fees and services with the community. The P-CSBAs continued to receive regular on-the job technical assistance for 3-6 months after the training from JITA staff to support their business development.

Process of social entrepreneurship development

JITA carried out an internal and external assessment of the P-CSBAs to understand their current monthly income stream, current business model, internal factors (such as previous experience, adaptability, communication, passion, drive and determination) and their external environment (such as family/community support and market information) that might affect their earnings. The findings showed that:

- social networking skills and family support have had a positive impact on the performance of P-CSBAs, while lack of previous health experience and competition with other health providers (e.g. village doctors, Traditional Birth Attendants (TBAs)) had a negative impact.
- barriers that prevented community use of the services offered by P-CSBAs included lack of awareness of their work and a preference for traditional home-based care as a result of illiteracy, poverty, and familiarity with and availability of TBAs.

Based on these findings, JITA then designed a support mechanism to cover the following areas.

- Business development training: the P-CSBAs were trained on the basics of social entrepreneurship, such as products (services and commodities), market-size calculation, competitor analysis, links with supply chains, and the planning and monitoring of self-employment, including financial records.
- Community mobilization: this consisted of a plan for each P-CSBA to carry out courtyard meetings and community mobilisation activities in areas where P-CSBAs have less coverage.
- Family support: given that few P-CSBAs were found to have family support, JITA staff conducted awareness-raising among family members about the importance of P-CSBA services and the associated opportunities and prestige for their communities.
- The development of alliances with TBAs/FWVs: as these are the greatest competitors for P-CSBAs, alliances with them are crucial.
- Private-sector linkages: local 'quack' doctors (unskilled practitioners) are selling over-the-counter drugs, which are mostly locally branded and of questionable quality. Given the demand for such drugs, as well as for health and hygiene products, JITA developed linkages with the private sector (e.g. pharmacies) in consultation with CARE, to provide products to the P-CSBAs at a special rate.
- To ensure that P-CSBAs are properly introduced to their communities and that their services are well-used, JITA has conducted the following activities:
  - *community-level awareness raising*: regular home-visit by P-CSBAs based on their daily route and awareness building plans; group meetings with JITA; health fairs; audio-visual media on P-CSBA services; health-hygiene promotion activities involving doctors, and yard meetings
  - *community mobilisation:* periodic meetings of JITA, community leaders/spokespersons and health workers; the creation of a monitoring team to track

5 JITA grew out of the Rural Sales Program piloted by CARE in 2004 to address the problem of highly informal rural marketing and distribution systems in Bangladesh. The project started with 25 poor women selling BATA shoes door to door in the northern region, but soon expanded to other areas with the then revolutionary idea of creating 'product operation baskets' for saleswomen, which would expand to include products from different companies like Square, Grameen Phone, Lalteer Seeds and Grameen Danone Foods Ltd.

Box 1: Case study of a P-CSBA

Nishad* lives in Dowarabazaar Upazila. A widow and a mother of two children, she was trained as a P-CSBA in November 2013. Although her catchment area is big (three wards of Mannargaon Union with 1,673 women of reproductive age), her average monthly income was stagnant, at around BDT 1,133. As a part of internal and external assessment of P-CSBA, JITA identified the reasons for the lack of growth in Nishad's income to the desired benchmark of BDT 5,000 per month. These included a lack of support from her extended family, her own feelings of insecurity when visiting new areas and a lack of awareness about the services she provides in the community. To address these, JITA developed an action plan that focused on engaging her family members and getting their support for child care while she goes to work, engaging local decision-makers and community leaders to ensure her security in the areas where she works, and introducing her to community members and building her credibility through yard meetings. JITA also helped Nishad to develop a list of health, hygiene and nutritional products that she can sell in addition to her skilled maternal and neonatal child health services. As a result of these efforts, her monthly income increased to BDT 7,500 by February 2015.

**Name changed for the purpose of anonymity.*

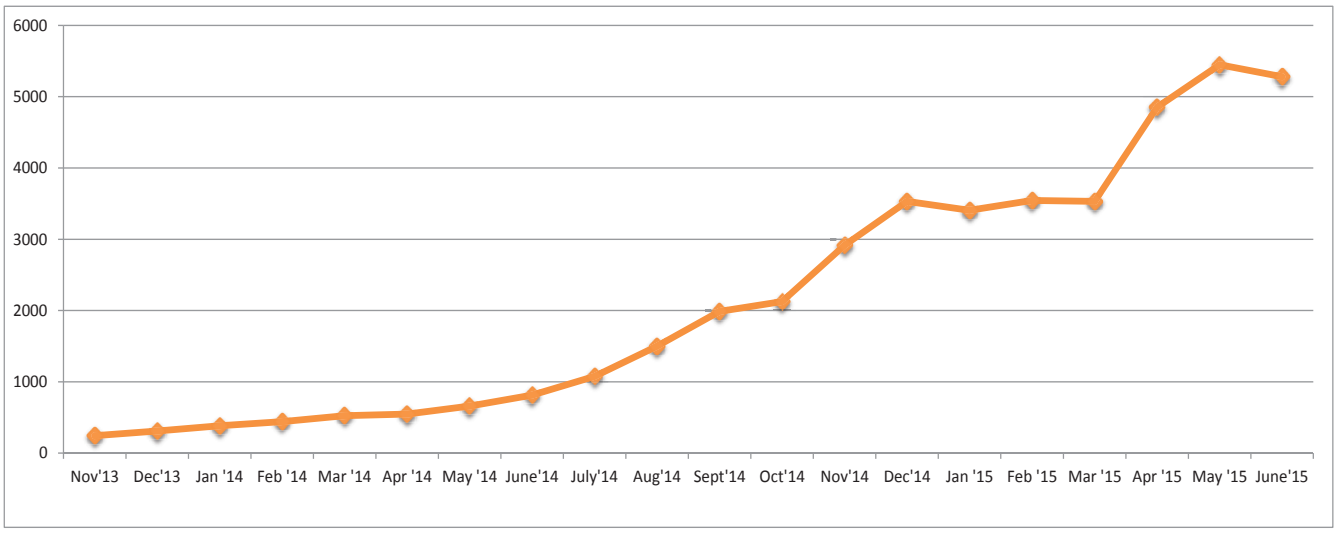
changing patterns of community service needs; the establishment of an integrated approach to P-CSBA services through linkages with women's groups, farmers' associations and youth clubs.

In addition to this support mechanism, JITA developed an appropriate business plan and model for P-CSBAs based on the findings of the assessment, and the potential customer base and earning opportunities. Each business plan that was developed factored in revenue, cost, investment, service-delivery modality and the specifics of the entrepreneur in order to create a suitable business model.

JITA provided technical assistance and regular supervision and monitoring visits to each P-CSBA, in order to ensure that they remained financially viable. Solutions and recommendations were identified as well as problems. JITA also analysed P-CSBAs' income trends and their emerging opportunities and constraints.

Since the beginning of the project, the P-CSBA total attrition rate within the CARE-GSK CHW Initiative has been around 6% - a level achieved by a combination of multi-dimensional efforts, such as the creation of an enabling environment for P-CSBAs by CmSSs, increased earnings trends, community appreciation and recognition, and close links with government health authorities.

Figure 6: Trends in the total monthly earnings (£) of P-CSBA



Source: CARE Bangladesh project data

Achievements

- Since 168 P-CSBAs started working in their catchment areas, they have earned a total of BDT 5,287,173 (£43,125). The average monthly earning per P-CSBA was BDT 3,896 (£33) in June 2015, up from BDT 536 (£4.40) in November 2013.
- About 55% of the P-CSBAs earned £24.80 or more and 28% earned £41.30 or more in June 2015. The trend is for a gradual increase in their monthly earning, although earning levels among individual P-CSBAs vary.
- About 40% of P-CSBAs have their own stalls at the markets, work out of their own homes or have a service delivery hut. P-CSBAs also provide MNCH services to pregnant women and children from fixed satellite clinics.

2.4 Public-private partnership

According to WHO, the term *public-private partnerships* (PPP) for health 'covers a wide variety of ventures involving a diversity of arrangements, varying with regard to participants, legal status, governance, management, policy-setting prerogatives, contributions and operational roles. Some so-called public-private partnerships could be more accurately described as public sector programmes with private sector participation' (WHO, 2015).

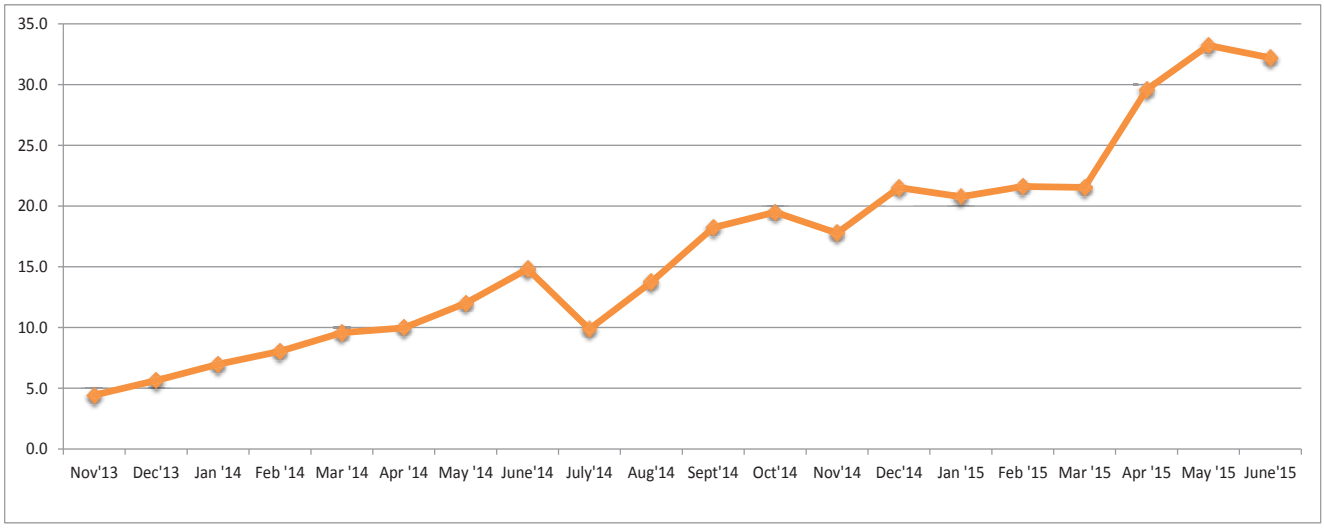
The success of the PPP under this project has been determined, in large part, by the fact that all stakeholders: leverage and share expertise; understand each other's contribution, responsibilities and resources; and are committed to creating a shared vision for everyone. Major actors in this partnership include CARE International and GSK, the MOHFW, local government, community and P-CSBAs. Their roles in this partnership are as follows;

- **CARE International and GSK** support the training of P-CSBAs and other community health workers, build community capacity through CmSSs, and facilitate linkages between P-CSBAs, community, local government and the broader health system.
- **MOHFW** issues accreditation and supervises P-CSBAs, provides supplies and other logistical support such as family planning commodities and vitamins, and provides MNCH referral services.
- **Community and local government** identify and select P-CSBAs, advocate for the use of their services, negotiate their fees and provide access support to poor families, monitor P-CSBAs performance and provide support when necessary.
- **P-CSBAs** provide basic maternal and child health services and issue referrals to health facilities, report to MOHFW on the supplies they receive, link with TBAs for joint deliveries and report on their services to UP/ health systems.

This PPP approach works not only horizontally (across different partners) but also vertically, through various levels and tiers of the decentralised health system.

- At the **community level**, the main focus is on mobilising the community by establishing a CmSS.
- At the **union level**, CARE facilitates linkages among community groups and the UP, as well as existing health workers at the community and union levels.
- At the **upazila level**, CARE and GoB facilitate linkages across the different levels of local government (union and upazila) and promote linkages with the UHC health providers to enable the referral system to manage maternal and child emergencies.

Figure 7: Trends in average monthly earnings (£) of P-CSBA



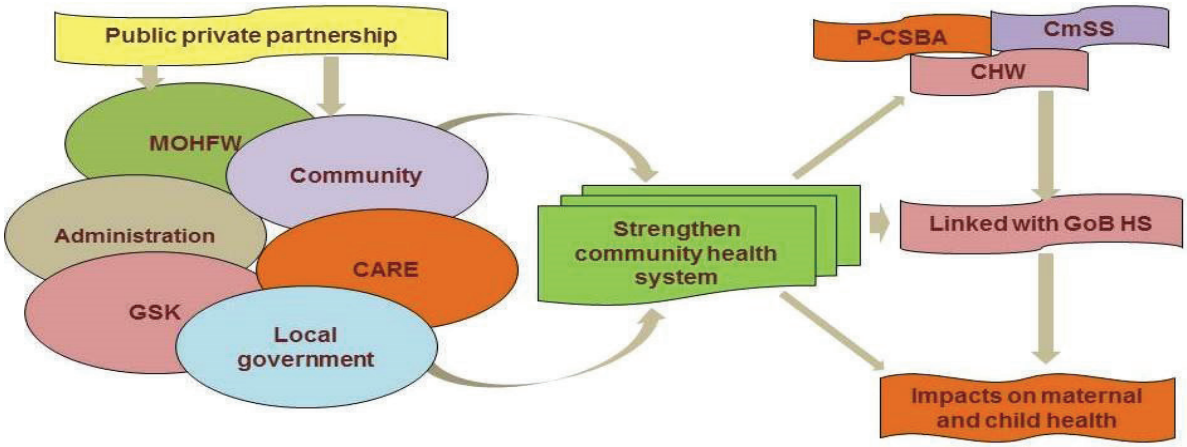
Source: CARE Bangladesh project data

- At the **district level**, CARE and GoB facilitate linkages with district-level officials and promote linkages with health providers within the community and other development partners working in the area. The CARE programme manager, based at the district level, creates linkages with the district providers and other development partners as well as coordinating the activities at upazila and union levels.
- At the **national level**, CARE and GoB facilitate linkages between the districts and national-level MOHFW, donors, and other development partners to learn and share lessons from other programmes.

Process of creating and maintaining a PPP:

- **Early inclusion and buy-in:** all of the partners identified above have been working together to develop and implement the project. As part of the project's development, the CARE project team met the GoB, WHO, UNICEF, UNFPA, selected donor agencies and international and national NGOs to present and discuss the feasibility of the proposed P-CSBA model. As such, the input and buy-in of these partners was secured before the project began. Through this process, local authorities and officials, such as district health managers and the Deputy Director for Family Planning, expressed their support and commitment, as well as their interest in learning more about the project's interventions and its innovative approaches to addressing critical gaps in health care.
- **Joint mapping:** CARE and local government carried out a situation analysis that mapped existing health services (both public and private) and providers (both skilled and unskilled, such as TBAs), their quality and accessibility. The analysis also looked at barriers to health services so that solutions could be developed. This information allowed the development of a system of functional referral linkages and advocacy for health staff and services where they were lacking.
- **Project monitoring and performance review:** project partners jointly monitored and reviewed project progress and achievements during implementation through various sharing and review mechanisms:
  - Every six months a joint performance monitoring team consisting of CARE, GSK and MOHFW reviewed progress, learning and challenges through site visits and meetings at the national level. This team also identified the responsibilities of each partner and the resources/support that were needed to ensure the success of the partnership.
  - CARE Bangladesh established a Technical Advisory Group (TAG) that provided input into the project strategy and learning agenda. The TAG was comprised of 8-10 key stakeholders from MOHFW, the Human Resource Management Unit, the Directorate General of Health Services and the Directorate General of Family Planning, UNICEF, UNFPA, WHO, Japan International Cooperation Agency, Save the Children, BRAC (formerly the Bangladesh Rural Advancement Committee), OGSB, GSK and CARE.The group met, on average, once a year to: review project progress and highlights; solicit feedback and guidance for programme strategies and align them with the priorities of the

Figure 8: Conceptual model of public-private partnership in the project



Source: CARE Bangladesh

GoB and MOHFW; facilitate cross-learning between stakeholders; and explore opportunities for joint advocacy, the scale–up of best practices and the leveraging of resources.
- An even wider circle of project stakeholders and supporters – the Stakeholder Group – was responsible for raising awareness and contributing to the advocacy efforts of the CARE-GSK partnership in Bangladesh. It served as a forum for the project team to share overall progress and lessons learned and solicit suggestions and recommendations for further improvements. The Stakeholder Group met twice and included members from business, civil society, academia and other relevant groups.

Achievements

In the past three years, CARE Bangladesh has developed a strong and viable model of working with public and private partners and stakeholders at different levels. It has developed new relationships and strengthened existing relationships between community groups and the health system (e.g. MOHFW, NGOs and the private sector) to create a functional referral system and forge closer links between community groups and local elected government bodies, such as Union and Upazila Parishads. As a result of a stronger relationship with the MOHFW, the ministry now provides space at 10 sub-districts for CARE project staff and involves CARE Bangladesh and other stakeholders in its regular monthly coordination meetings, as well as district and sub-district monthly coordination meetings.

The project is also receiving continuous Demand Side Financing (DSF) support from the government in two sub-districts (Sulla and Jagannathpur). This WHO-supported government activity provides monetary support to both maternal health-service providers and recipients, including project P-CSBAs and women in the community. The Institute of Public Health and Nutrition supplied 2.5 million Iron and Folic Acid tablets to be distributed by P-CSBAs. The Directorate General of Family Planning has provided misoprostol tablets, while MOHFW has also supported the provision of Helping Baby Breathe (HBB) kits for P-CSBAs. And, as mentioned, skills laboratories were established at each sub-district hospital; and medical officers and consultants working in these hospitals provide need-based skills training to the project's P-CSBAs.

3 Conclusions and considerations for the future

A number of key lessons can be drawn from this project. First, continued commitment from the highest levels is necessary, including appropriate policies and measures, to both strengthen community health systems through a multi-level approach that involves PPP, and to replicate and scale-up the model/approach. This support and commitment requires:

- the involvement of key government stakeholders in the development of the model from the initial stages and their support, insights and approval
- ongoing advocacy and evidence on the effectiveness of the approach to ensure support, uptake and replication.

Strong, effective, sustainable and accountable community health systems are only achievable with the involvement of (and linkages between) different levels of the health system and both private and public sector providers. Collaboration (both vertical and horizontal) between government health facilities, local government, community groups, NGOs and P-CSBAs is, therefore, essential. Mechanisms and processes to allow for linkages and involvement include:

- joint performance reviews at union level by GoB staff, P-CSBAs, NGOs and private providers with leadership from the MOHFW
- joint monitoring and data-collection processes to ensure transparent and inclusive decision-making, accountability and planning
- regular visits by the MOHFW from national and district levels to monitor project performance and provide support
- monthly coordination meetings with district Health and Family Planning departments and with district administrations
- regular meetings of a TAG and a Stakeholder Group that includes key stakeholders from government, the corporate sector, NGOs and maternal and child experts to provide overall guidance and review strategies and approaches.

Partnerships between government and the community are critical to address geographical, social and financial

barriers to accessing health services (especially for poor and marginalised communities) and to leverage and mobilise resources. This requires:

- the operationalisation of these partnerships at lower levels through, among other processes, referrals between the community and health service provider level
- the effective functioning of referrals, with secondary and tertiary health facilities that are both responsive to cases referred from lower levels and able to provide high quality services.

Innovative partnerships between the private and public sector, including in the form of the P-CSBAs, have been very effective in addressing both geographical and wealth inequities in access to health services, particularly in remote areas. For this model to be effective and sustainable, the P-CSBAs need to be trained in both technical and business-related skills.

- To ensure continuity of services in the community, the P-CSBAs need to be financially sustainable, which reinforces the need for training in financial management.
- On-the-job training, support and close supervision are all necessary to provide technical support (on both the health and business side) and to motivate the P-CSBAs.
- It is critical to raise awareness of the role of the P-CSBAs at community level to ensure their acceptance and, therefore, their long-term sustainability.
- It is also critical to gain family support for the work carried out by the P-CSBAs, especially in societies where the mobility of girls and women is restricted. So awareness raising among family members is an important part of the process.
- Given the potential overlap and competition with other community-based health workers, such as TBAs, alliances and collaboration need to be fostered, e.g. referrals among these providers or/and their allocation of different geographical coverage areas.
- Linkages between P-CSBAs and the broader health systems are critical to ensure their sustainability and continuity – representatives from the health systems need to be trained so they can support the P-CSBAs on an ongoing basis and when external support ceases.
- The further institutionalization of this initiative is important and can be carried out through ongoing advocacy work with national-level policy-makers, aiming to scale up this model across Bangladesh and achieve the ultimate goal of expanding access to health services.

Overall this project has been remarkably successful in developing an effective and sustainable PPP model to strengthen community health systems, with the involvement of a range of stakeholders at different levels of the health system. Despite its success, however, a number of challenges remain: working with government counterparts can sometimes be challenging, given operational and staffing issues in governmental health agencies – staff vacancy rates range from 20-40% and absenteeism is common. Geographical barriers, including remoteness and poor transportation links, remain obstacles for those both seeking and providing care. Social, cultural and religious norms remain critical barriers and limit the mobility, decision-making power and education of girls and women, leading to, among other things, low motivation for girls and women to become P-CSBAs. Nevertheless, it is critical that, based on the unique experiences of CARE Bangladesh, and particularly the P-CSBA model, this approach be replicated and scaled-up both within Bangladesh and beyond, adjusted to different local needs and contexts.

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