



BANGLADESH

BRAZIL

ETHIOPIA

LIBERIA

# COMMUNITY HEALTH WORKERS IN BANGLADESH

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June 2020



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## EXEMPLARS IN GLOBAL HEALTH

**EXEMPLARS IN GLOBAL HEALTH AIMS TO HELP PUBLIC HEALTH DECISION MAKERS** around the world find success at scale. With input from in-country and global experts, we analyze countries that have made extraordinary progress in important health outcomes and disseminate the key takeaways. Our hypothesis is that the lessons contained in this growing list of data-driven narratives will be a resource to leaders committed to improving health and achieving success in their countries.

We use all available and globally accepted data sets within an identified time horizon to pinpoint countries that outperformed peers in key areas of public health, controlling for factors like economic growth. Guided by research partners and technical advisors, we also consider geographic diversity, data availability, and research feasibility to select Exemplar countries. We then conduct further research and analysis to validate our initial assessment.

The Exemplars in Global Health program has identified a set of countries that have made notable progress in establishing and scaling community health worker programs. This report seeks to identify the policies and program characteristics that made these successes possible—and to determine which of them might be applicable elsewhere.

We define Community Health Workers (CHWs) as health care providers who extend the reach of primary health care systems by working in homes, community institutions (such as places of worship or markets), or peripheral health posts not usually staffed by doctors or nurses. CHWs are typically selected from, serve, and answer to the communities where they live and work. Their formal training generally ranges from a few weeks to up to two years. For a full list of CHW services and the World Health Organization's definition of CHW, on which our definition is based, please refer to the "WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes."<sup>1</sup>

It is estimated that at least half of the world's population does not receive the full package of essential health services they need. In most cases, a combination of economic barriers, geographic barriers, and a shortage of health care workers prevent people from accessing care.

Community health workers can help fill this gap. They can be a powerful tool for reaching marginalized communities, addressing constraints in access to healthcare, and in achieving behavior change. CHW programming is most effective when tailored to reflect the specific problem being addressed and the local context.

There is strong evidence that CHWs can help strengthen primary health care systems by linking communities to the broader health system, boosting health seeking behavior, and ensuring patients receive simple cost-effective preventive care and evidence-based interventions in their own communities. CHW programs can serve as a critical piece of a broad, universally accessible health system extending the reach of the health system and delivering high quality health services to vulnerable people.

Despite existing evidence on the potential impact of community health approaches, there are few studies that outline the processes and practices that enable countries to implement large scale, comprehensive and effective community health programs integrated into the health system. Additionally, the context and supporting systems most conducive to scale have not been adequately documented or analyzed.

We present this case study to help further the global conversation, as well as in-country discussions, about when community health worker programming is most appropriate. This study also aims to highlight how countries can design, scale, and manage community health worker programs to address their most important health challenges.

## WHY IS BANGLADESH AN EXEMPLAR?

### KEY POINTS

- » Bangladesh's CHW program was among the first in the world.
- » A patchwork of government and NGO CHW programming helped the country overcome scarce human and financial resources to deliver critical primary care to more than 100 million rural residents.
- » Bangladesh's program has, for more than 40 years, adapted to address the nation's most pressing health challenges.

The first CHW program in Bangladesh started shortly after the country's independence, as the cash-strapped government's innovative attempt to provide family planning information and services to rural residents. It proved to be a turning point. The government had hit upon a remarkably efficient and effective health care delivery model for a densely populated—yet still rural—country with few doctors and nurses, even fewer rural clinics and, at least initially, low demand for care.

What makes Bangladesh's story unique is that for the next 40 years both government and NGOs iterated on the CHW model—sometimes in collaboration and sometimes in parallel. The result has been robust pluralistic CHW programming noteworthy for large impact and scale, data-driven innovative programming, and integration into the larger health system.

NGOs were critical to this success. With CHW programming that grew to rival the government's in size, NGOs helped Bangladesh achieve remarkable improvements in health outcomes in three ways:



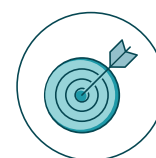
#### NGOS SUPPORTED GOVERNMENT PROGRAMMING

NGOs helped the government expand and strengthen government CHW programming, test new approaches, and better understand and address challenges through research.



#### NGO-LED PARRALLEL PROGRAMMING

NGOs developed their own programming that has delivered care to large numbers of Bangladeshis.



#### THE GOVERNMENT OUTSOURCED-WORK TO NGOS

NGOs served as government contractors, working for the government to address geographic or programmatic gaps. These activities included leading community engagement, from educating mothers about ORS to promoting government immunizations campaigns.

Initially, in the country's early years, the government's reliance on NGOs and its outsourcing of some community health worker programming and related research was a recognition of both limited government resources and capacity, and NGOs' deep expertise and comparatively vast resources. This outsourcing strategy had the added benefit of buffering CHW programs from political interference and a slow, unresponsive, risk-averse, and poorly resourced bureaucracy.

Recognizing the strength and diversity of NGO approaches, by the late 90s the government had shifted its role. It saw itself less as a provider of CHW programming and more as a purchaser of services—increasingly contracting with NGOs for CHWs services.

More recently, amid a profusion of NGO CHW programming and a dizzying patchwork of programs that are at times complementary, supplementary, and overlapping, the government has shifted again. It is currently working with NGOs to develop standards for training and care, as well as the country's first national CHW strategy to better coordinate and regulate varied programs. With this, the government hopes to address inefficiencies and fragmentation (including growing health inequities) and challenges in coordination and management (including various CHW cadres lacking common training or coordination).

Throughout, the government could not have had better equipped partners for this endeavor. The indigenous non-profits that have led CHW programming in Bangladesh alongside the government, including BRAC and icddr,b, have deep roots in Bangladesh's rural communities and rich expertise in research, monitoring, and evaluation.

Together, the NGOs and government have expanded CHW programming beyond its initial focus on family planning, to address child health in the 1980s, maternal health in the 1990s, and universal health care in the 2010s.

Such robust programming had modest roots. Initially, there was little demand for health care in rural areas. CHWs recruited patients, visiting homes, mosques, and community institutions. They educated rural residents about the safety and benefits of family planning services and immunizations. They also provided medicine for common but deadly child illnesses like diarrhea and acute respiratory infections. Slowly, communities that had lived for generations without access to such health care, began to demand it. This was a watershed moment for health care in Bangladesh. To meet the growing demand for care, the government built 13,000 community clinics, staffed them with CHWs, institutionalizing the role of the CHW and reducing the amount of time CHWs spent traveling to visit patients.<sup>1</sup> It also increased the amount of time available for patient care and formally connected thousands of rural villages with the national health system for the first time.

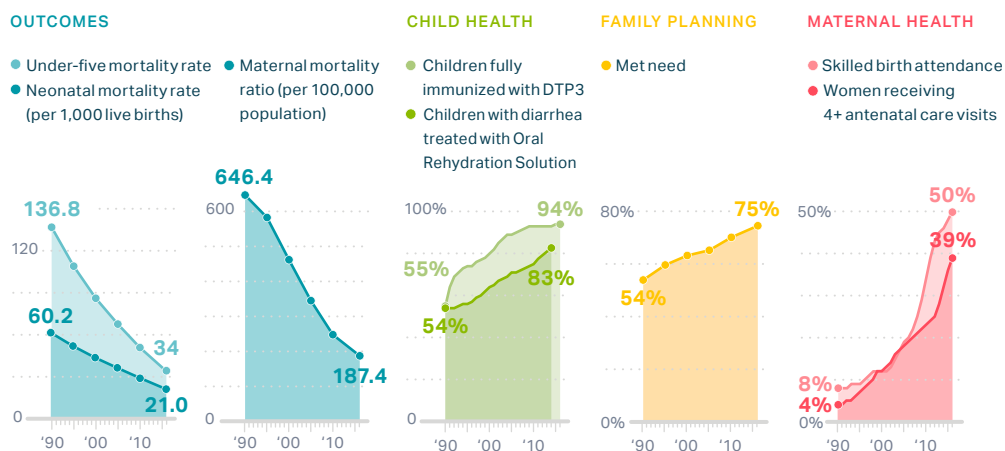
Today, approximately 130,000 CHWs work to deliver health education, preventive, promotive, and limited curative care across Bangladesh's rural areas.<sup>2</sup> About 50,000 of these CHWs work for the government, 50,000 work for BRAC, and the remainder work for other NGOs and the private sector.

These cadres have unmistakably transformed the country, empowering women and facilitating broad health improvements. Between 1990 and 2015, Bangladesh achieved a majority of health-related Millennium Development Goals by reducing under-five mortality rate by 75 percent, infant mortality rate by 72 percent, neonatal mortality rate by 65 percent, and maternal mortality ratio by 71 percent.<sup>3</sup> The contraceptive prevalence rate among rural women has increased by a factor of 10 from the 1970s to today.<sup>4</sup> The percent of rural children who receive the critical DTP3 vaccine has increased from near zero in the 1980s, to more than 90 percent today.<sup>5</sup>

For this reason, Bangladesh's unique and diverse CHW programming may hold lessons worth adapting and replicating.

Between 1990 and 2015, Bangladesh achieved the majority of health-related Millennium Development Goals by reducing under-five mortality by 75 percent, infant mortality by 72 percent, neonatal mortality by 65 percent, and reducing maternal mortality by 71 percent.

### Trajectory of key health indicators in Bangladesh, 1990–2016



Data source: Institute for Health Metrics and Evaluation (IHME); Demographic and Health Surveys (DHS)

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## WHAT DID BANGLADESH DO?

### KEY POINTS

- » More than 130,000 CHW, most of them women, have been trained to provide a growing basket of critical services—shifting the status of women in rural Bangladesh and connecting them with the formal health system for the first time.
- » A total 13,000 community clinics across the country have helped institutionalize CHW programming and connected communities with the formal health system.
- » CHW programming has mobilized communities to demand, support, and utilize CHWs.

### A RANGE OF COMPLEMENTARY PROGRAMS AND PARTNERS

Bangladesh's government, its civil society partners, and even private sector actors created a patchwork of overlapping, supplementary, and complementary CHW programs that delivers a range healthcare, from health education and preventive care, to simple treatment for common illnesses. The programs grew and shifted in response to data on health challenges and the CHWs' own performance.

Bangladesh is remarkable not only for the number of CHW cohorts, but also for the programs' focus on women's empowerment, sustainability, and community mobilization and engagement with regard to both the CHWs themselves and the clinics where many of them work. We will discuss each of these aspects in this section.

No NGO has more robust CHW programming than BRAC. In this section, we will compare BRAC's CHWs with the government's cohort.

Government, NGO, and private sector entities have each used CHWs to increase demand for and expand access to a wide range of critical health services across Bangladesh. While each cadre has its own training, management and supervisory mechanisms, package of services, and incentive system, there are similarities across programs.

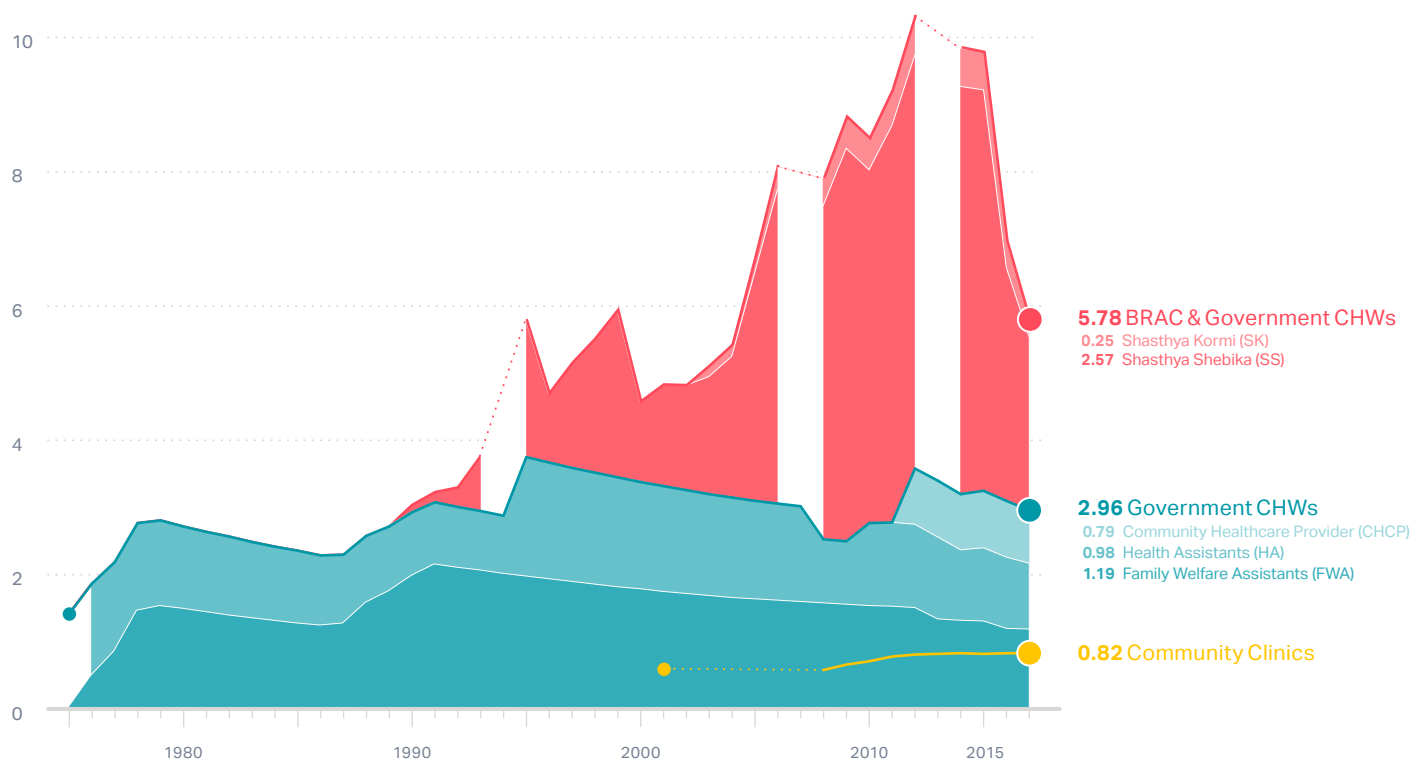
Chief among them are:

- » an emphasis on empowering and serving women
- » the use of data to drive decision-making
- » the development of innovative and adaptable programming
- » a reliance on partners

Each of these cadres provides another window into understanding Bangladesh's success in improving health outcomes through a patchwork of programs. And, as a whole, these cadres demonstrate both the rich diversity of approaches and the risk of duplication of efforts.

## Ratio of community healthworkers to population in Bangladesh , 1975–2016

Ratio to 10,000 population



Data source: El Arifeen, S. 2013; Government of Bangladesh; BRAC; Phillips, et al, 1994.

Although founded in the late 1970s, the BRAC corps was not formalized until the early 1990s.

Indeed, the various NGO cadres have not, among themselves, coordinated the delivery of health services by geography, patient type, or service type. Nor have NGOs necessarily concentrated their efforts in areas underserved by the government.

### BRAC CHWs

NGO CHWs outnumber the government's CHWs by a wide margin (80,000 to 50,000). The largest cohort of NGO-supported CHWs is BRAC's cadre, which has existed almost as long as the government's program. Like the government's program, BRAC's CHW program evolved from a vertical approach—specifically a focus on access to family planning—to a broader range of basic preventive care.

BRAC's CHWs are selected from BRAC's village-level microfinance organizations. Studies have demonstrated that connecting microfinance programs with health education magnifies the impact of health education programming.<sup>1</sup> This may be the case with BRAC CHWs, as they can reinforce their health messaging at regular microfinance group meetings. Further, the women attending microfinance meetings have, by virtue of their participation in microfinance groups, secured additional assets and enhanced their roles as decision-makers within their families. This role puts them in a stronger position to act on the health information provided by CHWs.

BRAC's CHWs consist of two cadres:

- » *Shasthya Shebika*: Shasthya Shebikas evolved from BRAC's use of CHWs for ORS, family planning, and immunization campaigns in the 1970s. Launched in 1990, these volunteers, recruited from BRAC's microfinance village organizations, are village women who receive three weeks of training and spend two to four hours a day, six days a week, visiting 10 to 30 families per day. They focus on disseminating health, nutrition, and family planning information, as well as motivating families to install tube-wells and improved latrines to improve hygiene. Their key demographic consumer is pregnant women. Shasthya Shebikas work to identify pregnant women in their community, explain the importance of antenatal care (ANC), and refer women to the more highly skilled Shasthya Kormis for ANC. They also educate pregnant women and mothers on the importance of Vitamin A supplementation, immunization, and birth control. Shasthya Shebikas also serve as low-level health providers, selling at a small markup, medicine for common ailments such as diarrhea and pneumonia, as well as vitamins, condoms, and safe delivery kits.

Shasthya Shebikas receive a commission based on their sales. There are also performance-based incentives for identifying pregnant women and signing them up for antenatal care, ensuring adherence to directly observed therapy (DOTS) for tuberculosis, and referring individuals to health facilities.

For their two to four hours of work each day, Shasthya Shebikas make a mean monthly income of about \$25 per month or \$300 per year. This income, though minimal, serves to reduce turnover. A 2011 study found that nearly 90 percent self-reported they became a Shasthya Shebika to earn an income.<sup>2</sup>

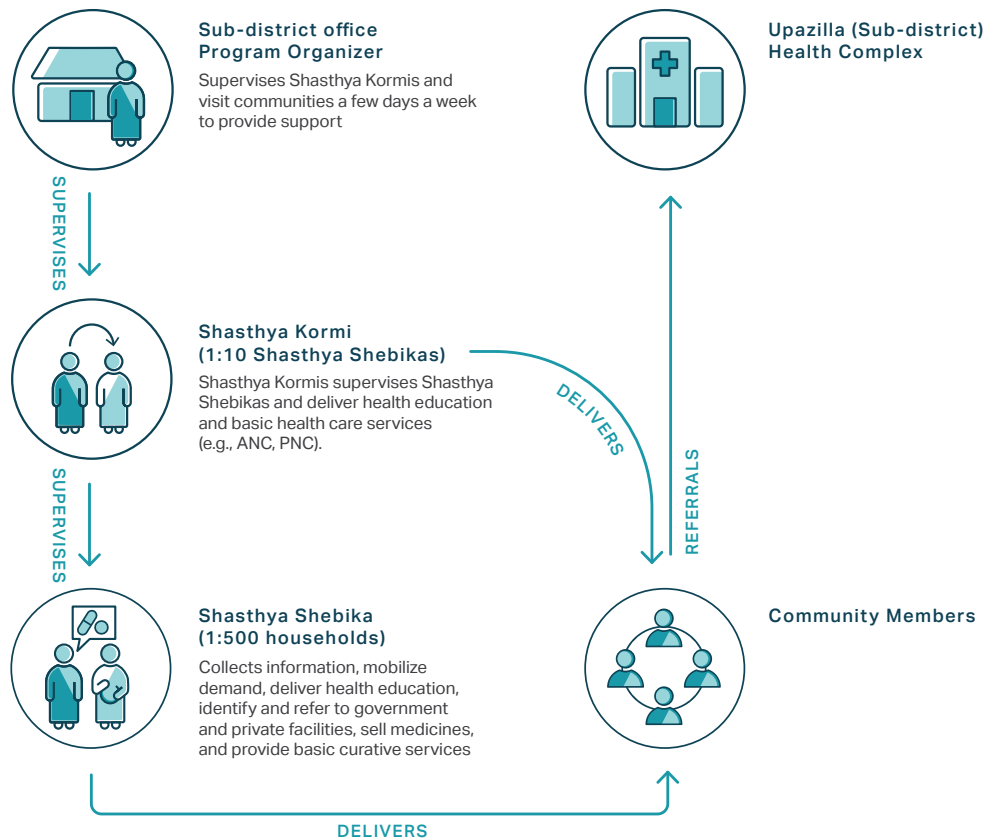
Initially, Shasthya Shebikas were supervised by BRAC's program organizers. But as the number of Shasthya Shebikas grew, two challenges arose: supervising them became a burden, and the Shasthya Shebikas had increased demand for care beyond their own bandwidth and abilities. To address those challenges, BRAC launched the Shasthya Kormis.

- » *Shasthya Kormis*: While Shasthya Shebikas often focus on generating demand for care, Shasthya Kormis, launched in 2005, work to deliver that care. Shasthya Kormis are village women with a minimum 10 years of schooling who receive three to four weeks of medical training. The cadre, which now numbers 4,000, provides maternal health services (ANC/PNC), assists with deliveries, provides special care to low birthweight babies, manages cases of diarrhea, acute respiratory infections, and other illnesses in children under five, oversees TB treatment, and facilitates health promotion.

Shasthya Kormis earn \$50 a month from BRAC, in addition to performance-based incentives, for their full-time work. Each Shasthya Kormi supervises 10 to 12 Shasthya Shebikas. The Shasthya Shebika meets with her supervising Shasthya Kormi two to three times each month. BRAC program organizers typically supervise five Shasthya Kormis. A medical doctor attends Shasthya Shebikas' meetings with their supervising program organizer, providing further guidance.

The initial training and the quarterly one- to two day-long refresher courses both Shasthya Kormis and Shasthya Shebikas attend are participatory, interactive, and highly contextualized. During the monthly refresher courses, for example, participants discuss real cases, and model best practices and treatments.<sup>3</sup> BRAC maintains both an independent control group that is responsible for managing the supply chain and an internal monitoring department. With the ultimate goal of improving quality, the department analyzes performance data to identify and address challenges and measure inputs and outputs, and quarterly performance.

**BRAC program overview**



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## SPOTLIGHT ON MONITORING AND EVALUATION—BRAC DATA MANAGEMENT

Steps	Individual	Data Collection	Data Reporting
1	Shasthya Shebika (SS)	SS collects/prepares: <ul style="list-style-type: none"> <li>» Medicine sales</li> <li>» Health commodity sales</li> <li>» Plan for household visit</li> <li>» Information on household visit</li> </ul>	<ul style="list-style-type: none"> <li>» Reports information in registrars to Shasthya Kormi on a regular basis</li> <li>» SS reports to SK</li> </ul>
2	Shasthya Kormi (SK)	SK collects the following information in one registrar (incorporating data from SS): <ul style="list-style-type: none"> <li>» Demographic (population, HHs, age disaggregated) information</li> <li>» FP data (total, adolescent, FP method user, new user, BRAC contribution)</li> <li>» Maternity data (identification, four+ ANC, one PNC, delivery, institutional delivery and skilled delivery)</li> <li>» Child health and nutrition (vaccination, diarrhea, pneumonia, EIBF, EBF and CF)</li> <li>» Education and counseling (forums and participants)</li> <li>» Services packages (number of clients received services for ANC, adolescent health)</li> <li>» IYCF and women's health</li> </ul>	<ul style="list-style-type: none"> <li>» Monthly compilation of services distributed at branch level</li> <li>» SK reports to program organizer</li> </ul>
3	Program Organizer (PO)	Collects data in registers, focus on supply chain: <ul style="list-style-type: none"> <li>» Register of health commodities (medicine sales information, medicine purchases and bill payment, revolving fund and presence of participants in refreshers)</li> <li>» Stock register</li> <li>» Daily buy and sell register (medicines, health commodities, glasses, pushtikona)</li> </ul>	<ul style="list-style-type: none"> <li>» Monthly compilation at branch level including PO register and aggregated data from all SK that he/she supervises</li> <li>» PO reports this data to the upazila manager</li> </ul>
4	Upazila Manager (UM)	<ul style="list-style-type: none"> <li>» Collects data from the report of program organizer, maternity/delivery center (outdoor consultation, delivery, referral, FP services), vision center (outdoor consultation, glasses and medicine sales, referral for surgeries)</li> <li>» Manages some register: stock register, petty cash register, meeting minutes register</li> </ul>	<ul style="list-style-type: none"> <li>» Makes monthly report for upazila, including: program performance report, financial report, HR report, data from PO synthesis of SK service delivery</li> <li>» Sends to district manager</li> </ul>
5	District Manager (DM)	<ul style="list-style-type: none"> <li>» Collects and compiles reports from upazila managers of respected District.</li> </ul>	<ul style="list-style-type: none"> <li>» Enters data in digital system producing district report</li> </ul>
6	Central Level	<ul style="list-style-type: none"> <li>» Automated compilation of data at district, division and national level</li> </ul>	

Data source: BRAC

### Government CHWs

The government has three cohorts of CHWs that reflect the organic development of its approach toward its bifurcated health system. They are:

- » Family Welfare Assistants
- » Health Assistants
- » Community Health Care Providers

Family Welfare Assistants work for the Directorate General of Family Planning and focus primarily on family planning, whereas Health Assistants and Community Health Care Providers work for the Directorate General of Health Services and have a broader focus. All three are selected, trained, and managed by their respective Ministry of Health and Family Welfare directorates. The community plays no role in the recruitment and selection of these government health workers. However, community groups do help manage and encourage the use of community clinics, where each of these three cohorts work.

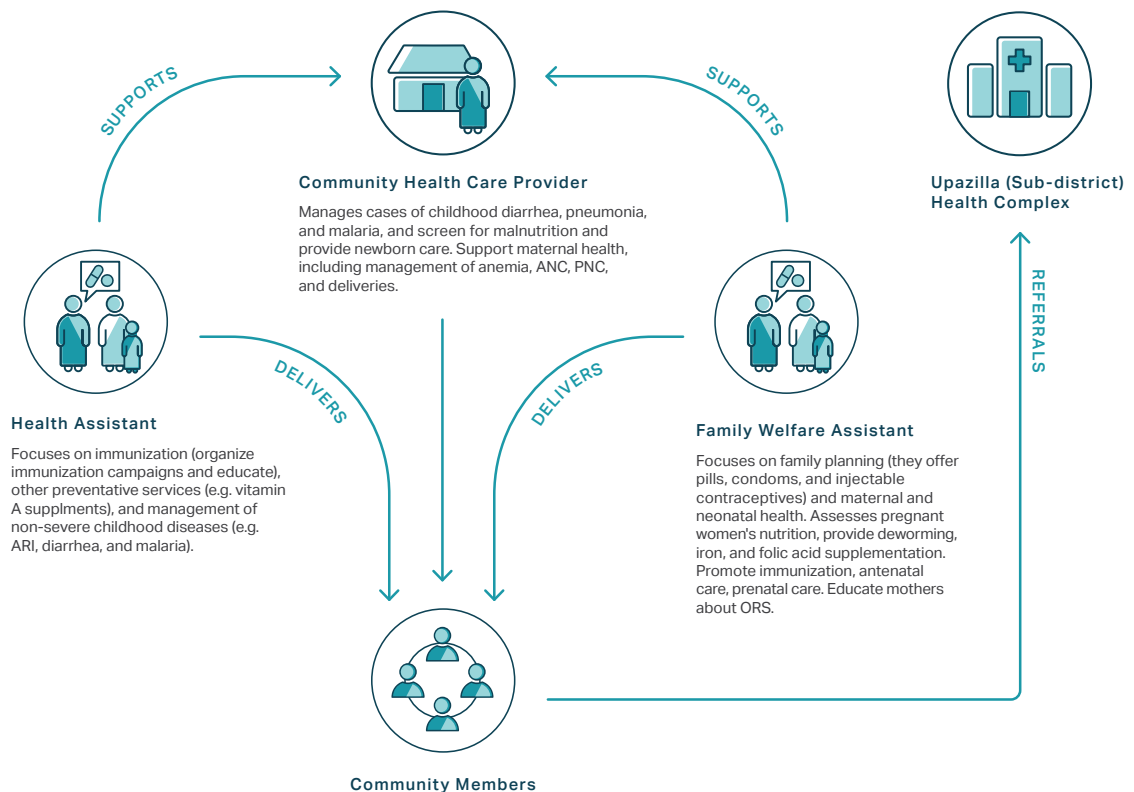
- » *Family Welfare Assistants:* Since the program's launch in 1976 as the first cohort of CHWs in Bangladesh to address the national priority of improving access to birth control, the number of Family Welfare Assistants has grown from 13,500 to the current 20,000. These women now spend about half their time working in community clinics and the other half making house calls. FWAs primarily focus on distributing family planning services and maternal and neonatal health. They offer pills, condoms, and injectable birth control. They assess pregnant women's nutrition and provide deworming, iron, and folic acid supplementation, as needed. They also promote immunization, antenatal care, prenatal care, and educate mothers on oral rehydration solution.
- » *Health Assistants:* Bangladesh's 17,000 Health Assistants also spend about half their time working in the community clinic, and half their time making house calls. They focus on organizing immunization campaigns, including educating communities about the need for and the importance of immunization. They also focus on improving children's health through preventive measures such as Vitamin A supplementation and the detection and treatment of common diseases and illnesses in children such as acute respiratory infection (ARI), diarrhea, tuberculosis (TB), and malaria.
- » *Community Health Care Providers:* Launched in 2009 with the establishment of Bangladesh's community clinics, the 13,000 Community Health Providers are the only CHWs in Bangladesh with clinical training who can, therefore, provide a higher level of services. Working full-time at the community clinic, Community Health Care Providers provide the widest range of preventive, promotive, and curative care. They manage cases of childhood diarrhea, pneumonia, and malaria, screen for malnutrition and provide newborn care. They also provide care to pregnant women, including the management of anemia, ANC, and PNC. They attend deliveries. Like both of the other government CHW cohorts, they also make referrals for more complex care.

The Family Welfare Assistants and Health Assistants both receive one month of training, though their training differs. Community Health Care Providers receive three months of training.

Despite the varying levels of training and responsibilities, all three cadres are paid \$182 per month. This salary reflects, in part, the relatively flat pay scale of government workers in Bangladesh. And all three cadres work, at least part-time, side by side at the local community clinic. The Community Health Care Provider works in the clinic exclusively, full-time.

There are multiple layers of supervision for the three CHW cohorts. A community group directly oversees the management of the community clinic and CHWs that work there. Just above that, at the union level, Health Assistants and Community Health Care Providers receive direct supervision from assistant health inspectors, and Family Welfare Assistants receive direct supervision from family planning inspectors. One level up from this at the upazila or sub-district level, all government CHWs attend monthly health meetings. And, at the national level, community clinics report data into the national Health Management Information System.

### Government program overview



### Private sector

Lastly, the private sector also uses CHWs to deliver health care services. These private sector efforts are largely separate from government and/or NGO efforts. They carry the potential for considerable duplication and inefficiencies because private sector CHWs, unlike NGOs, do not participate in local health sector coordination mechanisms such as the monthly upazila health committee meetings.

The most well-known private sector CHW program may be that of the Social Marketing Company. This large effort is a spin-off from a project previously managed by the international NGO Population Services International. The Social Marketing Company selects rural women as community entrepreneurs. It provides them and local pharmacy agents with basic training on public health issues, along with instructions on how to appropriately and effectively dispense and communicate to patients the proper administration of basic public health products and drugs. The 10,000 women serving as CHWs in this effort and local pharmacy agents make a small profit by obtaining products, such as contraceptives and zinc syrup, at wholesale, and selling at retail.

### **REGULAR HOUSE CALLS**

From the earliest CHW efforts in family planning, government and NGO programming has consistently incorporated house visits. This is not just a straightforward way of literally meeting patients where they are, but also serves as a powerful mechanism for monitoring community needs.

During house calls, government CHWs take a household inventory of basic demographic information including risk factors, health, and living conditions, and track all services delivered to the household. This data is shared with supervisors and used for planning purposes. This feedback loop enables programs to adapt to changing needs and ensures that local cultural and financial realities are considered as part of program design.

**“A KEY SUCCESS FACTOR OF OUR WORK IS MONITORING AND EVALUATION. WE ARE CONSTANTLY PRODUCING DATA AND SEEKING TO BETTER UNDERSTAND COMMUNITY CONTEXT. I WOULD SAY THAT THE CHW IS THE FIRST RESEARCHER IN THE COMMUNITY BECAUSE THEY ARE CONSTANTLY INTERACTING WITH COMMUNITY MEMBERS. THEY UNDERSTAND WHAT THE NEED IS IN THE COMMUNITY AND THEY HELP US CONTINUOUSLY ADAPT OUR SERVICES TO MEET THESE CHANGING NEEDS”**

—MULTILATERAL INSTITUTION STAKEHOLDER<sup>4</sup>

BRAC also incorporated regular household visitation, information collection, and surveillance into their programming. Shasthya Shebikas are expected to visit 10-30 homes per day. The Shasthya Shebika shares all data she collects in each household with her manager, who tracks it in a registrar. This ensures the Shasthya Kormis have a good sense of the needs and service use of each client.

It is important to note that data collected by these government CHW cadres have, until recently, not been shared.

### **COMMUNITY MOBILIZATION**

At the outset, Bangladesh realized its health challenges did not reflect a simple supply-side problem. There was also little demand for health care in poor, remote, and culturally conservative rural villages accustomed to living without it.

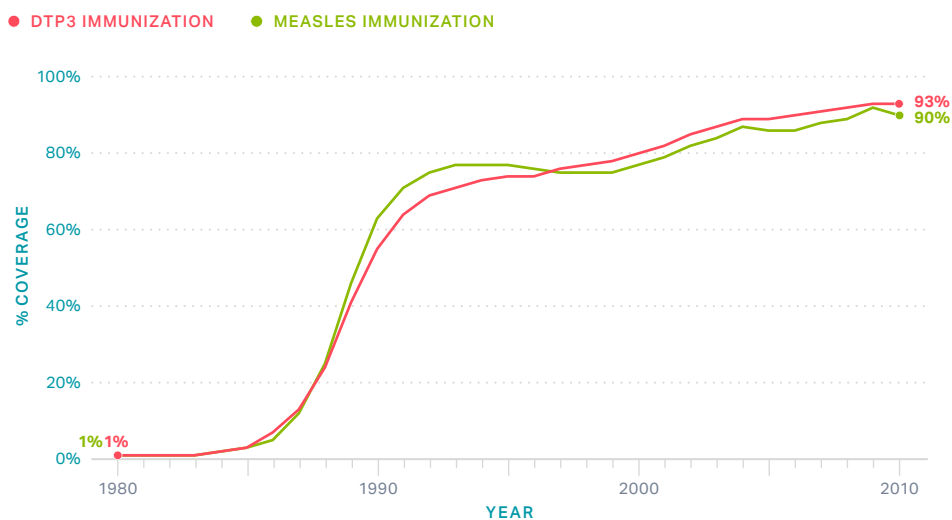
CHWs have been expected to spur demand. They have leveraged their local knowledge and contacts with local leaders and civic groups to build interest in and support for important health campaigns and interventions.

CHWs efficiently mobilize communities to increase service uptake and support health campaigns through grassroots marketing efforts and user-centered design. This is illustrated by examining Bangladesh’s approach to immunization.

In 1985, despite attempts to improve immunization rates, Bangladesh's BCG (tuberculosis), MCV1 (measles), Pol3 (polio), TT2+ (tetanus) immunization rates were the lowest in South Asia.<sup>5</sup> That same year, the government launched an ambitious immunization program. But this time, it partnered with BRAC and CARE, whose CHWs mobilized community members to participate in the immunization campaign.<sup>4</sup>

The mobilization, which involved going door-to-door to educate parents about the importance of immunization, was so effective that the program reached 90 percent (24 million) of children in the country in a single day.<sup>6</sup> Immunization coverage rates climbed from under five percent in 1985 to over seventy percent in 1995. A 2000 study conducted by CORE group inferred that higher immunization rates in some divisions were correlated with the use of CHWs and mass communication tools.<sup>7</sup> By 2010, immunization coverage had reached over ninety percent.

## Immunization coverage



Data source: Institute for Health Metrics and Evaluation (IHME); Demographic and Health Surveys (DHS)

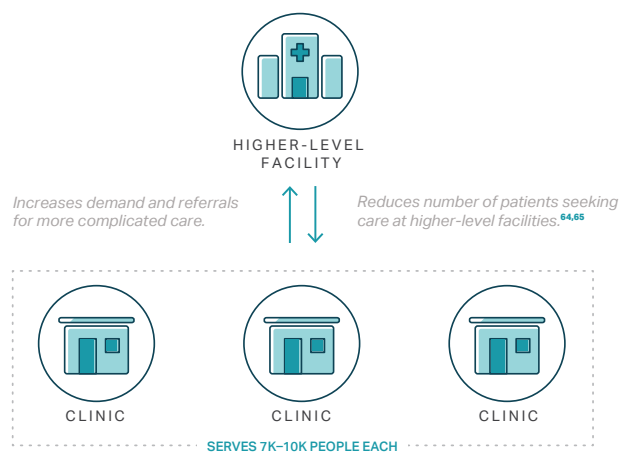
Likewise, to increase the use of oral rehydration solution (ORS) in rural areas, BRAC trained CHWs to teach mothers how to prepare ORS at home. Research found that women would be more willing to use ORS if they could make it at home, rather than having to travel to a health facility with their sick child. BRAC believed that framing ORS as a household issue, rather than a medical one, would increase use. BRAC and icddr,b worked together on a series of pilots before working in collaboration with the government to distribute the product.<sup>8</sup> During scale-up, BRAC researched reasons for low adoption and found that CHWs, having no experience with ORS and little understanding of why diarrhea was so dangerous to children, did not understand how or believe that ORS worked. BRAC brought them from the field to research labs in Dhaka to show how ORS worked. These CHWs were then advised to explain the science to community members, and to sip the ORS themselves during household training sessions, to convince mothers that the solution was healthy and would not harm their children.

This refinement of messaging and intensive focus on mobilization helped increase the rate of ORS treatment to more than 50 percent by the early 1990s.<sup>9</sup>

### COMMUNITY CLINICS STAFFED BY CHWS

The year 1998 marked a milestone for Bangladesh's efforts to improve health care. It was the year the country established a standard package of essential services and a "one-stop" health care model. Its center point was the community clinic—where the standard package of services would be provided by CHWs.<sup>10</sup>

#### Community clinic reach



This investment in a national network of brick-and-mortar clinics, alongside CHW programming, is in line with the emerging global consensus: that investments in community-level facilities and community health workers complement one another.<sup>11</sup> As CHWs seed demand for health care, the clinics improve CHWs' ability to meet that growing demand by reducing the need for travel to patients' homes, and increasing time available for treatment.

Moreover, the clinics serve as a pivotal gateway in two ways: they increase demand and referrals for more complicated care, ensuring patients who require complex care receive it, and they reduce the number of patients seeking care at higher-level facilities who could be just as well-served at lower-level ones. By screening patients, local health clinics rationalize the utilization of higher-level facilities for more serious health issues.<sup>12,13</sup>

While a change in government leadership mothballed clinics for nearly a decade, the political winds shifted again in 2008, allowing clinics to reopen. By 2016, more than 13,000 community clinics were operational and staffed by all three cadres of government CHWs.

Each community clinic serves a population of 7,000 to 10,000 people. The clinic—usually a simple, two-room building—is a tangible demonstration of a community's commitment to health care.

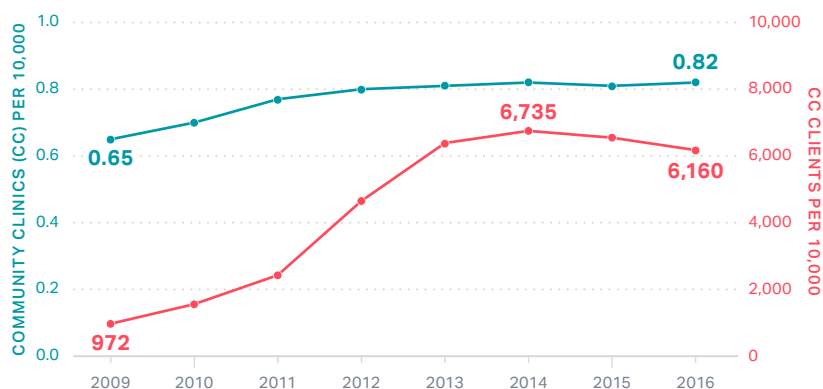
Community engagement with clinics starts from the very beginning. The clinics are constructed on land donated by the community. While costs incurred for construction, medicines, service providers, logistics, and other inputs are borne by the government, each community is asked to raise funds to defray general operating costs.<sup>14</sup> The clinics are also managed by local community groups. It is notable that the government uses clinics to provide communities with more than just health care—the clinics give communities a voice in the health care they receive.

Today, 80 percent of Bangladesh's population is within a 30-minute walk of a community clinic, marking a significant step toward access to care.<sup>15</sup> The clinics provide basic medicine, first aid, MNCH services, IMCI, family planning education and services, immunization. They treat acute respiratory infections and diarrhea, provide nutritional education and micronutrient supplements, and screen for non-communicable diseases (such as diabetes). Finally, they refer complex cases to higher-level facilities, when necessary.<sup>15</sup> Approximately 30 percent of community clinics also have Community-Based Skilled Birth Attendants (Family Welfare Assistants or female Health Assistants and female Community Health Care Providers with special training) who perform uncomplicated deliveries at the clinic itself.

While initial utilization of the clinics was low, by 2016, over 100 million people had used the clinics with one million of those patients being referred to higher-level facilities.

### Community clinic and annual clients per 10,000 population

● NUMBER OF COMMUNITY CLINICS (CC) PER 10,000 ● NUMBER OF CC CLIENTS PER 10,000

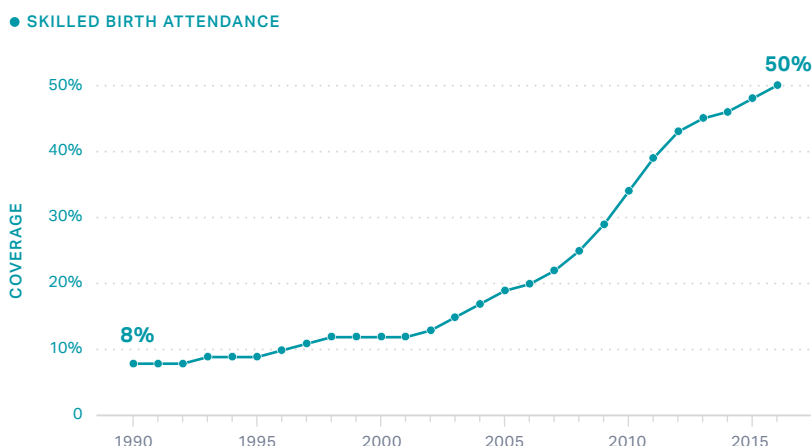


Data source: Ministry of Health and Family Welfare (MOHFW) of Bangladesh

The availability of community clinics and the presence of community-based skilled birth attendants contributed to significantly increase both the percentage of women giving birth in a health facility (rising from 23 percent to 47 percent) and the percentage of births attended by a medically trained provider (rising from 34 percent to 49.8 percent) between 2010 and 2016.

Today, community clinics are the government's flagship health program. They are monitored and evaluated through the fourth Sector-Wide Approach Health, Nutrition, and Population Sector Program (HNPS) 2016–2022, and financed with government, pooled and non-pooled donor funds, and community support.<sup>16</sup>

## Proportion of births attended by skilled health personnel



Data source: Institute for Health Metrics and Evaluation (IHME)

### WOMEN'S EMPOWERMENT

To appreciate why women's empowerment became a critical part of many of the CHW programs in Bangladesh, it is helpful to consider the position of women in rural areas shortly after independence.

Upon gaining independence in 1972, Bangladesh faced a crisis. Bangladeshi women were having, on average, seven children.<sup>17</sup> Other than that of Afghanistan, this was—at the time—the highest fertility rate in South Asia and 50 percent higher than the global average of 4.67 children.<sup>17</sup> During this period, the country simply could not provide basic services for its citizens. Reducing fertility was a mechanism for both improving child health and reducing maternal deaths.<sup>18</sup> Founding Prime Minister Bango Bandh Sheikh Mujibur Rahman called the high fertility rate the “number one challenge for Bangladesh” and made increasing access to family planning services a national development priority.<sup>8</sup>

The challenge was complicated. Only about five percent of Bangladeshi women had access to contraceptives. And the country was deeply conservative. *Purdah*, the seclusion of women in their homes by religious edict, prevented women from accessing basic health care, including effective contraception.<sup>19</sup> Even those women whose families and communities allowed them to leave their home would be hard-pressed to find quality care. The country had among the lowest level of human resources for health in the world. In 1970, Bangladesh's density of doctors was about half that of neighboring Pakistan and India.<sup>20</sup> Even today, the World Health Organization estimates that Bangladesh has only seven skilled health professionals per 10,000 citizens. That is roughly one third the minimum recommendation.<sup>21</sup>

The government and many NGOs, including BRAC, responded by developing CHW programming with three key goals: to improve the standing of women by shifting sociocultural norms in extremely conservative rural areas, to provide economic opportunities for women, and to improve women's health.

**“WE CAN'T SPEAK ABOUT COMMUNITY HEALTH WITHOUT SPEAKING ABOUT HOW THE COMMUNITY VIEWS WOMEN, AND THAT'S WHY WE STARTED TO THINK ABOUT THIS WORK AS INTEGRATED AND MORE ABOUT POVERTY REDUCTION THAN JUST HEALTH, AND THIS REQUIRES FEMALE EMPOWERMENT AND SHIFTING HOW SOCIETY VIEWS THESE WOMEN.”**

—NGO LEADER <sup>4</sup>

The focus on women's empowerment may be strongest and most apparent in BRAC's approach.<sup>22</sup> Key to their strategy was the exclusive reliance on women to serve as CHWs and deliver primary health care for women and children. CHWs are empowered through the engagement in community activities, building their skills and capacity for decision-making, and providing them with income-generating activities. BRAC positions CHWs as agents of change, empowering women and the community.

Hiring women as CHWs has three important impacts: it elevates the status of the women serving as CHW, it broadly improves the status of women within the community as a whole, and it increases access to health information and health care for women.

#### **Elevating the status of women serving as CHWs**

First, CHWs play an important and highly visible role in the community. They must meet with government officials and local authorities. Indeed, interviews with women CHWs reveal that many initially turned down the position because they did not feel ready for the responsibility and senior role within their community. A 1992 study of the Bangladesh National Family Planning Program found that by providing employment opportunities for women, in an environment where professional employment opportunities for women were scarce, the program improved the status of the women health workers.<sup>23</sup>

#### **Elevating the status of women broadly**

Second, hiring women as CHWs shifts social norms by placing women in leadership positions within the community. The same 1992 study found that by providing employment opportunities for women, in an environment where professional employment opportunities for women were scarce, the program broadly made social boundaries less rigid for other women in the community.<sup>23</sup> Research shows female CHWs improve social acceptance of the mobility and work of young women.<sup>24</sup>

**"I REALLY FEEL THAT THE CHW EFFORTS, THE EDUCATION THAT WE HAVE PRIORITIZED FOR THEM IN OUR COUNTRY, HAVE SHIFTED HOW WE VIEW WOMEN. THEY ARE SEEN NOW AS SOURCES OF INCOME FOR THEIR FAMILIES AND A LOT OF THAT HAS TO GO TO THE CREDIT OF LITERACY, MICROFINANCE, EDUCATION PROGRAMS AS WELL. ALL THIS HAS CHANGED VALUES THAT ULTIMATELY HAS SUPPORTED BETTER HEALTH OUTCOMES."**

—NGO LEADER \*

#### **Reaching women with health information and health care**

Lastly, our key informants reported that women serving as CHWs are more effective at negotiating the delivery of health services and information to other women in culturally conservative settings.

#### **DEVELOPING A SUSTAINABLE MODEL**

BRAC's CHW programing is based on an innovative entrepreneurship model designed to maximize sustainability by providing income to the organization and the Shasthya Shebikas, while delivering free or low-cost care to the rural poor. The key components of BRAC's sustainability approach are: limited initial investment and limited recurrent costs (e.g., commodities, training, mobilization), entrepreneurship development through in-kind seed fund, and the compensation provided to the Shasthyka Shebika (markup from selling goods, mobilization fee for each service provided, and performance based incentives).

The cycle starts with BRAC selling commodities, many of them made by BRAC community groups, to the Shasthya Shebika at a small mark-up. The Shasthya Shebika, who does not receive a salary, then sells these products, after another small mark-up, to the families she serves. She then pockets the mark-up. Finally, BRAC charges community members, on a sliding scale, a small fee for some of the health services the Shasthya Shebika delivers. BRAC uses these fees to keep the program going.

The sustainability of the program is dependent not only on these small mark-ups, as products make their way to patients, but also on achieving low turnover and high-performing Shasthya Shebikas.<sup>2</sup> It costs nearly \$90 to train a Shasthya Shebika. Reducing the number of Shasthya Shebikas who need to be trained each year is critical to the program's sustainability. Currently, the annual dropout among Shasthya Kormis is 5–10%, and among Shasthya Shebikas is 10–15%, which hinders sustainability.<sup>25</sup>

BRAC is working to address this. To offset opportunity costs and ensure each Shasthya Shebika is motivated and able to establish a robust service, she is initially given a fixed revolving fund for buying essential medicine and health commodities from BRAC at cost price. She is also eligible for a second loan from her village BRAC microfinance group. Given that the income earned by a Shasthya Shebika depends primarily on her experience, competition (remoteness from local health infrastructure and other providers), interpersonal communication skills and reputation and community acceptability, BRAC recently significantly reduced the number of CHWs (from 80,000 to 50,000).<sup>26</sup> This reduces competition between CHWs and allows each CHW to serve a larger area with more families, thereby increasing her potential income.

For the majority of Shasthya Shebikas, even the meager income they receive through this work is a large motivator for their service.<sup>2</sup>

**“THE EARNINGS FROM SHEBIKA ACTIVITIES HAVE ASSISTED ME TO BECOME ECONOMICALLY INDEPENDENT. FROM THIS EARNING I MEET THE EXPENDITURE OF MY CHILDREN’S EDUCATION AND OTHER NECESSITIES; ONCE I EVEN MANAGED TO RUN MY FAMILY ON THIS INCOME WHEN MY HUSBAND WAS BEDRIDDEN DUE TO AN ACCIDENT...”**

—SHASTHYA SHEBIKA <sup>22</sup>

### **ENGAGEMENT WITH COMMUNITY INSTITUTIONS**

In addition to house calls, government and NGO CHWs work out of a wide variety of community institutions, from mosques and schools, to local businesses. In these spaces, CHWs may educate the public about the importance and availability of health care in the community, through posted signs or occasional in-person lectures. By using these public spaces to deliver their public health messages, the CHWs gain the passive endorsement of those institutions and reach patients where they are.

This third-party endorsement has helped position the CHWs as a community pillar providing important services.

Perhaps the best example of this is BRAC's use of its microfinance groups to recruit its CHWs, who then use microfinance groups to disseminate health message.

## BRAC CADRES

Characteristics	Shasthya Shebika (SS)	Shasthya Kormi (SK)
<i>Scale (Latest)</i>	~42,000	~4,000
<i>Ratio</i>	» Rural population: 1:2,000	» Rural Population: 1: 25,000
<i>Qualifications</i>	» Female; 25 years or older; current member of BRAC or outside the VO; youngest child is not < two years old; socially acceptable to village; family agrees to her involvement	» Married; acceptable to their community and have passed grade 10 in school
<i>Selection</i>	» Mostly self-selected by VO; local Gram committee also play a role in nominating prospective SSs; BRAC makes final selection	» Selected by BRAC
<i>Training</i>	» 3–4 weeks pre-service training; additional special training every quarter (2–5 days depending on need) for TB DOTS, diagnosis/treatment of pneumonia, and safe motherhood » Monthly refresher training	» 3–4 weeks pre-service training » Monthly refresher training
<i>Services</i>	SSs are expected to visit 250–300 households per month or approximately 10–30 homes per day (~4hs of work per day). Household visits include identifying health needs (i.e. pregnancy), disseminating health messages, motivating service use and monitoring and referring as necessary. The SS regularly shares this household information with the SK who tracks in a registrar. » <i>Health promotion and education:</i> WASH, nutrition, FP, pregnancy related care, childhood immunization » <i>Community Mobilization:</i> National immunization, vitamin A and deworming campaigns; immunization and FP satellite clinics » <i>Treatment of common ailments:</i> Fever, cold, anemia, peptic ulcer, diarrhea, amoebic dysentery, scabies, pneumonia. » <i>Other medical duties:</i> Early diagnosis and treatment of malaria, ARI, TB suspects (DOTS), identify pregnant women and refer to SK » <i>Sale of drugs and health commodities:</i> Paracetamol, vitamins, anti-histamines, ORS, antacids, iodized salt, sanitary napkins, condoms, contraceptive pills, safe delivery kits, reading glasses. SS procure supplies during the monthly refresher trainings from the BRAC office, local shops or BRAC production centers. BRAC produces sanitary napkins, delivery kits and iodized salt. BRAC works with pharma to procure commodities for their offices, earning a small markup on the products.	» Conduct health education sessions » Provide ANC and PNC, assist with deliveries » Provide essential newborn care, including special care for low birth weight babies » Offer community based management of acute malnutrition; manage diarrhea and acute respiratory infections of children » Oversee TB treatment and conduct immunization programs
<i>Supervision</i>	» Shasthya Kormi (SK); 1 SK supervises approximately 10–12 SS; Each SS engages with their respective SK 2–3 times per month » SK provides feedback to the SS at the monthly refresher training using individual performance report » BRAC analyzes performance data from these reports to understand current health situation and performance challenges » There is also an independent monitoring department that measures inputs/ outputs and quarterly performance.	» Part time- Generally work a 3–5 hours per week » Establish and lead a one-to-five network or WDG » Program organizers (PO) who are supervised by the Area Program Manager and a medical doctor » POs, SK, SS and the medical doctor all attend the monthly refresher training/performance meeting

Characteristics	Shasthya Shebika (SS)	Shasthya Kormi (SK)
<i>Incentives</i>	<ul style="list-style-type: none"> <li>» Access to an additional microfinance loan from BRAC</li> <li>» Income from selling medicines and health products as well as performance based incentives for identifying pregnant women and signing them up for antenatal care delivered by the SK, ensuring adherence to TB DOTS and referring individuals to health facilities</li> <li>» SS generally earn income of ~US\$ 25/month; 86% became an SS to earn an income</li> </ul>	<ul style="list-style-type: none"> <li>» Regular monthly salary of ~US\$ 50/month + performance based incentives</li> </ul>
<i>Start Date</i>	<ul style="list-style-type: none"> <li>» 1991 (early iterations started in mid-1970s)</li> </ul>	<ul style="list-style-type: none"> <li>» 2005</li> </ul>
<i>Evolution</i>	<ul style="list-style-type: none"> <li>» 1970s and 1980s: Family Planning; OTEP and EPI; Vitamin A and WASH education</li> <li>» 1990s: Formalization as part of EHC; IMCI and MNCH; TB</li> <li>» 2000s: Supervision by SKs</li> </ul>	<ul style="list-style-type: none"> <li>» 2000s: Focus on MNCH program</li> <li>» 2010s: Greater focus on health packages and education</li> </ul>

## GOVERNMENT CADRES

Characteristics	Family Welfare Assistants (FWA)	Health Assistants (HA)	Community Healthcare Provider (CHCP)
<i>Scale (Latest)</i>	~20,000	~17,000	~13,000
<i>Ratio</i>	<ul style="list-style-type: none"> <li>» Design: 1:7,000-10,000 (CC catchment); originally 6k</li> <li>» Rural population: 1:5,500</li> </ul>	<ul style="list-style-type: none"> <li>» Design: 1:7,000-10,000 (CC catchment); originally 6k</li> <li>» Rural Population: 1:6,500</li> </ul>	<ul style="list-style-type: none"> <li>» Design: 1:7,000-10,000 (CC catchment); originally 6k</li> <li>» Rural Population: 1:8,000</li> </ul>
<i>Qualifications</i>	<ul style="list-style-type: none"> <li>» Female, 10 years of schooling and a local resident</li> </ul>	<ul style="list-style-type: none"> <li>» Male or Female, 10 years of schooling, local resident</li> </ul>	<ul style="list-style-type: none"> <li>» Male or Female, 10 years of schooling, local resident, capable of operating a computer</li> </ul>
<i>Selection</i>	<ul style="list-style-type: none"> <li>» Selected and managed by Directorate General of Family Planning</li> </ul>	<ul style="list-style-type: none"> <li>» Selected and managed by DGHS</li> </ul>	<ul style="list-style-type: none"> <li>» Selected and managed by Directorate General of Health</li> </ul>
<i>Training</i>	<ul style="list-style-type: none"> <li>» 3 weeks; ad-hoc refresher training (1-2 days)</li> <li>» Some FWAs receive additional 6 months training to become community skilled birth attendants.</li> </ul>	<ul style="list-style-type: none"> <li>» 3 weeks; ad-hoc refresher training (1-2 days)</li> <li>» Some female HAs receive addtl 6 months training to become community skilled birth attendants.</li> </ul>	<ul style="list-style-type: none"> <li>» 6 weeks theoretical/6 weeks practical ad-hoc refresher training (1-2 days); CHCP is only provider that is considered to have clinical training</li> <li>» Some female CHCPs receive addtl 6 months training to become community skilled birth attendants</li> </ul>
<i>Services</i>	<ul style="list-style-type: none"> <li>» Community Clinic (50%): Support CHCP in all activities; focus on family planning and maternal health</li> <li>» Outreach (50%): Visit households 1X/ 2 months; register couples and pregnant mothers, record deaths and births; mobilize demand for and dispense short-term family planning products (pills, condoms, depo); provide family planning and nutrition counselling and to a lesser extent promote EPI/ANC/PNC/ CBNC and ORS; refer upstream</li> </ul>	<ul style="list-style-type: none"> <li>» Community Clinic (50%): Support CHCP in all activities; focus on EPI and children's health</li> <li>» Outreach (50%): Visit households 1X/ 2 months; mobilize demand for and administer vaccines at eight designated "EPI sites"; provide vitamin A supplements and ORS; detect and treat ARI, diarrhea, TB and malaria, usually at the community clinic; conduct health promotion; provide referrals to upstream clinics</li> </ul>	<ul style="list-style-type: none"> <li>» Community Clinic (100%): Provide basic preventive, promotive and curative care (ANC, PNC, CBNC, family planning, first aid, pneumonia, anemia); dispense medicines; some perform normal deliveries at the community clinic; referral to upstream facilities</li> </ul>

Characteristics	Family Welfare Assistants (FWA)	Health Assistants (HA)	Community Healthcare Provider (CHCP)
<i>Supervision</i>	» Family planning inspectors and assistant family planning inspectors (~2x/month); CG also provides oversight	» Health inspector and assistant health inspectors (2x/month); CG also provides oversight	» Health inspector and assistant health inspectors (2x/month); CG also provides oversight
<i>Incentives</i>	» Salaried civil servants: US\$ 182/month	» Salaried civil servants: US\$ 182/month	» Salaried civil servants: US\$ 182/month
<i>Start Date</i>	» 1976	» 1960s	» 2010
<i>Evolution</i>	» 1970s: Emerged as key investment in reducing fertility rate by increasing contraceptive prevalence » 1980s: EPI/ORS targeted towards women » 1990s and 2000s: Begin to work at community clinic 50% of the time and receive CSBA training	» 1960s: Malaria and smallpox vaccinators » 1980s: EPI/ORS » 1990s and 2000s: Begin to work at community clinic 50% of the time and receive CSBA training » 2000s: TB Program/Community Clinic /CSBA	» 2000s: Community Clinic and training as community skilled birth attendance (CSBA)

Note: Multipurpose Volunteers (MPV) (under proposal) Currently, there is a proposal under consideration to staff 5 community health volunteers in the catchment area of each Community Clinic to help conduct community outreach and surveillance. They would be paid through performance incentives rather than full time salary. Would be managed by the DGHS but selected by the community.

## COMPLETE GOVERNMENT AND BRAC ESSENTIAL HEALTH SERVICE PACKAGE

Characteristics	Family Welfare Assistants (FWA)	Health Assistants (HA)	Community Healthcare Provider (CHCP)	Shasthya Shebika	Shasthya Kormi
<i>Health promotion and education</i>	<ul style="list-style-type: none"> <li>» WASH</li> <li>» Family planning</li> <li>» Nutrition</li> <li>» Pregnancy and newborn related care (ANC/PNC/CBNC)</li> </ul>	<ul style="list-style-type: none"> <li>» WASH</li> <li>» Infectious diseases (HIV, TB, Malaria)</li> <li>» Nutrition</li> <li>» Child health</li> <li>» NCDs (hypertension, diabetes, cancer, smoking)</li> <li>» Mental health</li> </ul>	<ul style="list-style-type: none"> <li>» WASH</li> <li>» Family planning</li> <li>» Nutrition</li> <li>» Pregnancy and newborn related care (ANC/PNC/CBNC)</li> <li>» Child health</li> <li>» NCDs (hypertension, diabetes, cancer, smoking)</li> <li>» Mental health</li> </ul>	<ul style="list-style-type: none"> <li>» WASH</li> <li>» Family Planning</li> <li>» Nutrition</li> <li>» Pregnancy and newborn related care (ANC/PNC/CBNS)</li> <li>» Child health</li> </ul>	<ul style="list-style-type: none"> <li>» WASH</li> <li>» Family Planning</li> <li>» Nutrition</li> <li>» Pregnancy and newborn related care (ANC/PNC/CBNS)</li> <li>» Child health</li> </ul>
<i>Community Mobilization</i>	<ul style="list-style-type: none"> <li>» Mobilize community members to attend national immunization, vitamin A and deworming campaigns</li> <li>» Mobilize community members to attend immunization and family planning satellite clinics</li> </ul>	<ul style="list-style-type: none"> <li>» Mobilize community members to attend national immunization, vitamin A and deworming campaigns</li> <li>» Mobilize community members to attend immunization and family planning satellite clinics</li> </ul>	<ul style="list-style-type: none"> <li>» Mobilize community members to attend national immunization, vitamin A and deworming campaigns</li> <li>» Mobilize community members to attend immunization and family planning satellite clinics</li> <li>» Mobilize community members to use community clinic services via community groups</li> </ul>	<ul style="list-style-type: none"> <li>» Mobilize community members to attend national immunization, vitamin A and deworming campaigns</li> <li>» Mobilize community members to attend immunization and family planning satellite clinics</li> </ul>	<ul style="list-style-type: none"> <li>» N/A</li> </ul>
<i>Family Planning</i>	<ul style="list-style-type: none"> <li>» Register and visit all eligible couples</li> <li>» Distribution of short-term family planning methods (oral contraceptives, condoms, depo)</li> <li>» Identify and refer clients for IUD and permanent methods</li> </ul>	<ul style="list-style-type: none"> <li>» N/A</li> </ul>	<ul style="list-style-type: none"> <li>» Distribution of short-term family planning methods (oral contraceptives, condoms, depo)</li> <li>» Identify and refer clients for IUD and permanent methods</li> </ul>	<ul style="list-style-type: none"> <li>» Sell short-term family planning methods (oral contraceptives, condoms, depo)</li> </ul>	<ul style="list-style-type: none"> <li>» N/A</li> </ul>
<i>Maternal and Neonatal Child Health</i>	<ul style="list-style-type: none"> <li>» Register and visit all pregnant women</li> <li>» Conduct birth preparedness plan</li> <li>» Assess pregnant women malnutrition status and conduct deworming as needed for pregnant mothers/women</li> <li>» Provide iron and folic acid supplementation</li> <li>» Provide tetanus toxoid vaccine at EPI outreach sites</li> <li>» Refer to community clinic and other clinics for ANC and PNC services</li> <li>» Identify and refer clients for obstetric emergencies/fistula</li> <li>» Identify and refer clients for newborn challenges, such as sepsis</li> </ul>	<ul style="list-style-type: none"> <li>» Provide tetanus toxoid vaccine at EPI outreach sites</li> </ul>	<ul style="list-style-type: none"> <li>» Identification and diagnosis of pregnancy</li> <li>» Registration of pregnancy</li> <li>» Provision of ANC and PNC</li> <li>» 30% conduct normal delivery and community based newborn care</li> <li>» Identify, manage, and refer clients for obstetric emergencies/fistula</li> <li>» Identify, manage, and refer postnatal complications</li> <li>» Detection and referral for severe reproductive health problems</li> </ul>	<ul style="list-style-type: none"> <li>» Identify pregnant mothers and refer to SK</li> <li>» Identifying high-risk pregnancies</li> <li>» Sell sanitary napkins</li> </ul>	<ul style="list-style-type: none"> <li>» Provide ANC and PNC</li> <li>» Referring women for tetanus toxoid vaccination</li> <li>» Monitoring nutrition and providing supplemental food for low birth infants</li> <li>» Assist with deliveries</li> </ul>

Characteristics	Family Welfare Assistants (FWA)	Health Assistants (HA)	Community Healthcare Provider (CHCP)	Shasthya Shebika	Shasthya Kormi
<i>Child Health</i>	<ul style="list-style-type: none"> <li>» Op8</li> </ul>	<ul style="list-style-type: none"> <li>» EPI: Conduct EPI at eight designated EPI "sites" within their coverage area</li> <li>» Counselling parents on immunization and adverse effects, registering children and following up</li> <li>» Provide vitamin A supplements</li> <li>» IMCI: Provide counselling to parents on danger signs, nutrition of sick child; identify danger signs and refer</li> <li>» Detect, treat and manage mild ARI with cotrimoxazole (work with CHCP)</li> <li>» Detect, treat and manage mild diarrhea with ORS (work with CHCP)</li> <li>» Screen for malnutrition</li> <li>» Prevent malnutrition through breastfeeding, deworming, micronutrient supplementation</li> <li>» Management of moderate, severe acute malnutrition (uncomplicated)</li> </ul>	<ul style="list-style-type: none"> <li>» EPI: Conduct EPI at the community clinic</li> <li>» Counselling parents on immunization and adverse effects, registering children and following up with defaulters</li> <li>» IMCI: Provide counselling to parents on danger signs, nutrition of sick child; identify danger signs and refer</li> <li>» Detect, treat and manage mild ARI with cotrimoxazole/amoxycillin</li> <li>» Detect, treat and manage mild diarrhea with ORS zinc</li> <li>» Conduct growth monitoring</li> <li>» Screen for malnutrition</li> <li>» Prevent malnutrition through breastfeeding, deworming, micronutrient supplementation</li> <li>» Management of moderate and severe acute malnutrition (uncomplicated)</li> <li>» Management of mild anemia</li> </ul>	<ul style="list-style-type: none"> <li>» Prevention, treatment and referral for fever, common cold, anemia, peptic ulcer, diarrhea, dysentery, scabies and pneumonia/ARI</li> <li>» Provide essential newborn care</li> <li>» Sales of ORS sachets and zinc tablets; cotrimoxazole</li> </ul>	<ul style="list-style-type: none"> <li>» Provide essential newborn care, including special care for low birth weight babies</li> <li>» Offer community based management of acute malnutrition</li> <li>» Manage diarrhea</li> <li>» Manage acute respiratory infections</li> <li>» Conduct childhood immunization</li> </ul>
<i>Communicable Diseases</i>	<ul style="list-style-type: none"> <li>» On an ad hoc basis help support health assistants and community healthcare provider with communicable disease prevention, detection and treatment</li> <li>» Activities are same as health assistants</li> </ul>	<ul style="list-style-type: none"> <li>» Detect, treat and manage malaria with antimalarials-uncomplicated first line (work with CHCP)</li> <li>» Detect and treat TB with DOTS</li> <li>» Referral for HIV counselling and testing</li> <li>» MDA for lymphatic filariasis</li> </ul>	<ul style="list-style-type: none"> <li>» Detect, treat and manage malaria with antimalarials-uncomplicated first line</li> <li>» Detect and treat TB with DOTS</li> <li>» Prevention of HIV infection</li> <li>» Referral for HIV counselling and testing</li> <li>» MDA for lymphatic filariasis</li> <li>» DOTS oral treatment for Kala-Azar</li> </ul>	<ul style="list-style-type: none"> <li>» Early diagnosis and treatment of malaria</li> <li>» Identifying TB suspects, referral for sputum examination, ensuring DOTS for TB patients</li> <li>» Sell antimalarial and bed-nets</li> </ul>	<ul style="list-style-type: none"> <li>» Oversee malaria treatment</li> <li>» Oversee TB treatment</li> </ul>
<i>Non-communicable diseases</i>	<ul style="list-style-type: none"> <li>» Counselling on screening for cervical and breast cancers</li> <li>» Teaching of breast self exam</li> </ul>		<ul style="list-style-type: none"> <li>» Screen for hypertension, diabetes</li> <li>» Screen for risk factors of CVD</li> <li>» Counselling on screening for cervical and breast cancers</li> <li>» Clinical breast exam</li> </ul>		
<i>Other</i>	<ul style="list-style-type: none"> <li>» Support CHCP in all activities; focus on family planning and maternal health</li> <li>» Record deaths and births</li> <li>» Refer for other maternal health services</li> <li>» Case identification and reporting of sexual violence</li> </ul>	<ul style="list-style-type: none"> <li>» Support CHCP in all activities, focus on EPI and children's health</li> <li>» Refer for other childhood health services</li> <li>» Help respond to emergencies</li> <li>» Case identification and reporting of sexual violence</li> </ul>	<ul style="list-style-type: none"> <li>» Referrals for more complicated services</li> <li>» Detection and treatment of minor ailments like headache, fever, cold, and cough, eye and ear care</li> <li>» Treatment of scabies and ringworm</li> <li>» Provide basic first aid</li> <li>» Case identification and reporting of sexual violence</li> </ul>	<ul style="list-style-type: none"> <li>» Sales of the following vitamins and medicines: Paracetamol, anti-histamines, antacids, vitamins A and B, iron supplements, multi-vitamins, iodized salt, sanitary napkins, reading glasses, antiseptic ointment and antiseptic liquid mebendazole and albendazole (deworming), and diapers</li> </ul>	<ul style="list-style-type: none"> <li>» Supervise SS</li> </ul>

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## HOW DID BANGLADESH IMPLEMENT?

### KEY POINTS

- » Bangladesh outsourced many elements of CHW programming to leverage the knowledge, resources, and experience of its NGO partners. The government's shift from provider of services to manager of services has allowed NGOs to take the lead in innovating, testing, and delivering care.
- » With research and a data-driven approach as a foundation, Bangladesh has continually adapted its programs to meet changing needs.

Bangladesh's government welcomed and leveraged partners, harnessing NGO expertise and experience to strengthen its own programming and to fill geographic and programmatic gaps it knew it did not have the resources or expertise to address. The resulting programs, both NGO- and government-led, are remarkable for their community engagement and data-driven approach. What's most interesting about Bangladesh's story is how the country developed, managed, and sustained such multi-partner programming and created synergies, which we will explore in this section.

### DATA-DRIVEN, ITERATIVE APPROACH

The design, implementation, expansion, and modification of Bangladesh's community health efforts, both government and NGO-supported, were informed by comprehensive data collection efforts.

- » In the 1970s, the focus was on addressing high fertility rates through family planning, when research showed the fertility rate in Bangladesh was 50 percent above the world average.
- » In the 1980s, prevention of and treatment for childhood illnesses (oral rehydration solution, expanded program on immunization) were added to the package of services when research showed that 63 percent of childhood deaths in Bangladesh were due to vaccine-preventable disease.
- » In the 1990s, maternal health (skilled birth attendance, antenatal care, postnatal care) and communicable diseases (tuberculosis) were added to the mix when research showed that less than five percent of deliveries occurred in a health facility and the maternal mortality ratio was over 500 per 100,000 live births.<sup>1</sup>
- » And finally, in the 1990s and 2000s, a broad package of essential health services was introduced when Bangladesh signed onto the Millennium Development Goals and the Sustainable Development Goals, based on global research supporting the benefits of universal health care.

**TIMELINE TABLE (GOVERNMENT: 1960–2015)**

	Major milestones	CHW cadre changes	Policy and context changes
<b>1960</b>	<ul style="list-style-type: none"> <li>» Promotes use of family planning products via field and clinic</li> </ul>	<ul style="list-style-type: none"> <li>» HAs focus on malaria and smallpox vaccination</li> </ul>	<ul style="list-style-type: none"> <li>» Rural health center scheme launched, with focus on building facilities at sub-district and union level to provide variety of MNCH services</li> </ul>
<b>1970</b>	<ul style="list-style-type: none"> <li>» Launches National Family Planning Program</li> <li>» Prioritizes IV fluids to treat diarrhea in clinics and for outbreaks</li> </ul>	<ul style="list-style-type: none"> <li>» FWA cadre launched (primarily education, counseling and distribution of FP methods)</li> </ul>	<ul style="list-style-type: none"> <li>» Bangladesh independence</li> <li>» First five-year plan and population policy (73-80); focus on rural health care; DGFP created and focus on family planning</li> </ul>
<b>1980–1984</b>	<ul style="list-style-type: none"> <li>» Launches national Oral Rehydration Program</li> <li>» Launches initial EPI efforts</li> </ul>	<ul style="list-style-type: none"> <li>» HAs shift to provide child health services (EPI, ORS, and Vitamin A)</li> <li>» FWAs begin to promote immunization, ORS and breastfeeding</li> </ul>	<ul style="list-style-type: none"> <li>» Second five-year plan and population project (80-85); focus on family planning</li> <li>» National Drug Policy adopted; leading to growth of pharmacies across the country</li> </ul>
<b>1985–1990</b>	<ul style="list-style-type: none"> <li>» Launches National Control of Diarrhea Disease Program (CDD) which integrates gov't and NGO ORS distribution</li> <li>» Launches national EPI program, integrating gov't and NGO EPI</li> <li>» Establishes facilities for maternal health to complement CHW</li> </ul>	<ul style="list-style-type: none"> <li>» 10K FWAs added to expand services into screening for complicated pregnancies, ORS and immunization for women</li> <li>» HAs cement focus on EPI</li> </ul>	<ul style="list-style-type: none"> <li>» Third five-year plan and population project (86-91); focus on EPI</li> </ul>
<b>1990–994</b>	<ul style="list-style-type: none"> <li>» Trains TBAs and midwives to improve skilled birth attendance; largely fails</li> <li>» Launches National TB program (NTP) in collaboration with NGOs</li> </ul>	<ul style="list-style-type: none"> <li>» FWAs collaborate with TBAs to increase SBA</li> <li>» HAs continue to focus on EPI</li> </ul>	<ul style="list-style-type: none"> <li>» Fourth five-year plan and population project (92-97); focus on integrating maternal and child health care, family-planning, nutrition care, and health education</li> </ul>
<b>1995–2000</b>	<ul style="list-style-type: none"> <li>» Pilots IMCI approach</li> <li>» Formal review of IMCI confirms feasibility</li> <li>» First launch of community clinics</li> </ul>	<ul style="list-style-type: none"> <li>» FWA and HA begin to provide services at the community clinic based on ESP policy designed through SWAp</li> </ul>	<ul style="list-style-type: none"> <li>» First SWAp- HSPP (1998-2003, including ESP and CC</li> </ul>
<b>2000–2004</b>	<ul style="list-style-type: none"> <li>» National IMCI strategy launched</li> <li>» Community clinics halted due to change in government</li> <li>» Maternal Voucher scheme introduced to increase use of facilities for delivery but largely unsuccessful</li> </ul>	<ul style="list-style-type: none"> <li>» Female HA/FWA trained to be Community Skilled Birth Attendants (CSBA)</li> <li>» HAs begin to provide IMCI services (mainly promotion)</li> </ul>	<ul style="list-style-type: none"> <li>» First SWAp- HSPP (1998-2003, including ESP and CC</li> </ul>
<b>2005–2010</b>	<ul style="list-style-type: none"> <li>» Community clinics revitalized</li> <li>» National malaria and MNCH programs are launched in collaboration with NGOs</li> </ul>	<ul style="list-style-type: none"> <li>» Community health care Promoter cadre created (100% at community clinic)</li> </ul>	<ul style="list-style-type: none"> <li>» Awami League returns to power</li> </ul>
<b>2010–2015</b>	<ul style="list-style-type: none"> <li>» Community clinics embedded into health sector planning</li> <li>» Community groups formalized to support community clinics</li> <li>» Focus on building health management information system that reaches down to community level</li> </ul>	<ul style="list-style-type: none"> <li>» CHCPs begin to receive SBA training</li> <li>» FWA, HA and CHCP formalize collaboration</li> </ul>	<ul style="list-style-type: none"> <li>» Third SWAp- HPNSDP (11-16), includes community clinics and prioritizes UHC and CC referrals and integration</li> <li>» UHC/ health finance strategy launched</li> </ul>

## TIMELINE TABLE (BRAC)

	Major milestones	CHW cadre changes
<b>1970</b>	<ul style="list-style-type: none"> <li>» Begins with focus primarily on disaster relief following Bangladesh war of independence</li> <li>» Experiments with community health worker approaches with focus on family planning and ORS</li> </ul>	<ul style="list-style-type: none"> <li>» Launches first CHW pilot with male paramedics</li> <li>» Launches revised pilot with female CHWs; focus on family planning and health promotion</li> </ul>
<b>1980–1984</b>	<ul style="list-style-type: none"> <li>» Launches and begins to scale home-based ORS through program called OTEP (initiated in 1979 after some piloting with ICDDR, b in the 1970s)</li> </ul>	<ul style="list-style-type: none"> <li>» Trains “ORS workers” as part of OTEP</li> </ul>
<b>1985–1990</b>	<ul style="list-style-type: none"> <li>» Continues to scale home-based ORS</li> <li>» Partners with government in EPI program</li> <li>» Develops child survival and essential health care (EHC) programs that create the foundation for further investments in community health</li> </ul>	<ul style="list-style-type: none"> <li>» CHWs trained to provide EPI</li> </ul>
<b>1990–1994</b>	<ul style="list-style-type: none"> <li>» Focus shifts to integrated development</li> <li>» Creation of women health development program</li> <li>» BRAC signs an MOU with the NTP to scale TB-DOTS across the country via CHWs</li> </ul>	<ul style="list-style-type: none"> <li>» Launches Shasthya Shebika community health volunteer cadre and begins to scale through the NTP and the EPI</li> <li>» Begin to use CHWs to detect and treat ARI</li> </ul>
<b>1995–2000</b>	<ul style="list-style-type: none"> <li>» Begins malaria control program</li> </ul>	<ul style="list-style-type: none"> <li>» TB program results in some increase in the number of BRAC CHWs</li> </ul>
<b>2000–2004</b>	<ul style="list-style-type: none"> <li>» Global Fund supports BRAC TB scale</li> <li>» Partners with government on IMCI strategy</li> </ul>	<ul style="list-style-type: none"> <li>» TB program continues to increase the scale of the CHW program rapidly</li> <li>» Shasthya Shebika’s play important role in national IMCI strategy</li> </ul>
<b>2005–2010</b>	<ul style="list-style-type: none"> <li>» Partners with government on national malaria control and MNCH programs</li> <li>» Launches Manoshi (urban CHW program)</li> </ul>	<ul style="list-style-type: none"> <li>» Launches Shasthya Kormi cadre to supervise Shasthya Shebikas</li> <li>» Shasthya Kormis are able to provide a higher level of maternal health care services such as ANC and PNC</li> </ul>
<b>2010–2015</b>	<ul style="list-style-type: none"> <li>» Revitalization of Shasthya Shebika program</li> </ul>	<ul style="list-style-type: none"> <li>» Addition of blood pressure screening, cancer screening and vision care</li> <li>» Reduction in size of Shasthya Shebika program to support larger service area and income generating opportunities</li> </ul>

This data-driven approach is supported by four central pillars of program design shared by many of the CHW efforts included in this analysis:

#### **Problem-driven approach**

CHW interventions are a response to an existing problem, rather than a solution looking for a problem. As such, they are expected to change as needs change. This approach necessitates the continual monitoring of needs and a system responsive to this data.

#### **Culture of research**

Continuous monitoring helps identify gaps in programming and low-performing programs. This starts with CHWs in the field collecting research. But it also includes important surveillance sites such as the International Centre for Diarrheal Disease Research, Bangladesh's (ICDDR, B) Matlab, just outside Dhaka, which have continually collected data on health trends and shared that data widely.

#### **Piloting and scaling**

Matlab has also served as a testing ground for government and NGO pilots. The piloting of new approaches in such an environment provides data that can be used to inform improvements and generates evidence for advocacy.

#### **Channels for innovation diffusion**

Just as important as this research is connecting the research community to policy makers to ensure the dissemination of evidence. The National Institute for Population Research and Training (NIPORT), established by the Ministry of Health and Welfare (MOHFW) in 1977 serves as a key link in this respect. NIPORT is an autonomous research institute which conducts public health surveys (e.g., demographic health surveys, maternal mortality survey, health facilities surveys, etc.) and implementation science studies, and then disseminates learnings from these studies to a broad range of government and NGO stakeholders. The hope is that these leaders then use presented learnings to make changes to the existing program, or design new programs to address these gaps and challenges.

For example, data from the 2014 Demographic and Health Survey showed the total fertility rate was much higher in Sylhet and Chittagong than in other divisions. NIPORT shared this finding with the Directorate General of Family Planning through a series of national consultations. The ministry then advocated for additional NGO-contracted CHWs to work in these areas to provide information about and access to modern contraceptives.

NIPORT also ensures the information gained through research helps shape the country's public health research agenda and is factored into the training of government health workers who provide family planning services, including FWAs.

### **LEVERAGING PARTNER'S RESOURCES**

**“WE SEE OUR ROLE AS THE COACH—ALWAYS ON THE SIDELINE—LOOKING AT THE DATA AND THEN BUILDING AWARENESS OF THE RELEVANT PARTIES ABOUT WHAT THE NATIONAL SURVEY RESULTS MEAN FOR THEM AND WHAT ARE THE EXPECTATIONS OF THE GOVERNMENT TO USE ADDITIONAL RESEARCH AND/OR PILOTS TO ADDRESS THE CHALLENGES IDENTIFIED IN THE NATIONAL SURVEYS.”**

—GOVERNMENT OFFICIAL<sup>2</sup>

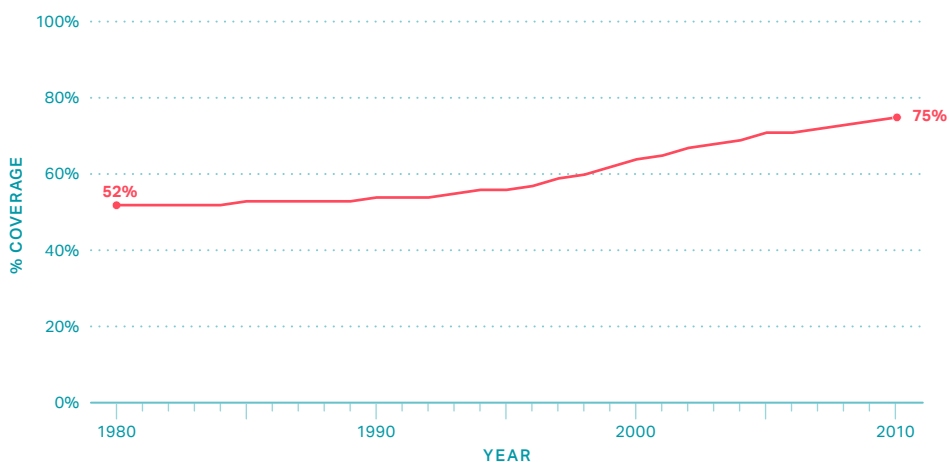
Throughout the four distinct phases in the evolution of Bangladesh's CHW effort—from a focus on family planning in the 1970s, to the addition of child health in the 1980s, then maternal health in the 1990s, to universal health care in 2010—one constant has been the government's reliance on NGO partnership to evaluate, innovate, adapt, expand, and improve programming to strengthen access to health care across Bangladesh.

Evidence of the government's heavy reliance on partner resources (financial and human) and expertise can be observed, from the very beginning. When the government wanted to test different approaches for its family planning CHWs, it turned for assistance to the international health research institute based in Bangladesh, icddr,b. The research institute rigorously tested various approaches and recommended an evidence-based best practice which the government adopted.

In the 1970s, when the government's clinic-based diarrhea treatment program to reduce child mortality had limited success, the government relied on an NGO to pilot a way forward. In this case, BRAC launched a CHW-supported program to teach mothers how to make and deliver ORS to their sick children at home without the support or involvement of highly-trained health workers. Again, the government adopted learnings from this program to inform the CHW-supported National Control of Diarrhea Disease Program in 1985, which, combined with BRAC's work with ORS, helped Bangladesh reduce diarrhea mortality and under-five deaths.<sup>3</sup>

### Oral rehydration solution (ORS) coverage

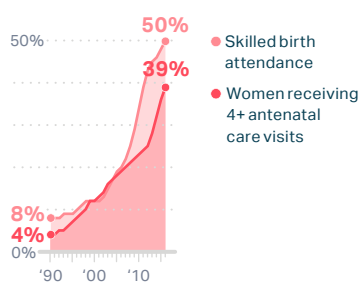
● PERCENT OF CHILDREN WITH DIARRHEA WHO USE ORAL REHYDRATION SOLUTION



*Data source:* Institute for Health Metrics and Evaluation (IHME); Demographic and Health Surveys (DHS)  
 ORS: Percent coverage of children (0–5 years) with diarrhea within the past 2 weeks that received oral rehydration solution

Later, in the early 1980s, the government contracted BRAC and CARE to train their own CHWs to mobilize support for immunization in regions where government CHWs were not yet firmly established. Immunization coverage rates (e.g., BCG, DTP3, measles) climbed from under five percent in 1985, to over seventy percent by 1995. By 2010, national immunization coverage had reached over ninety percent.<sup>3</sup> This contributed to significant reductions in child mortality. Today, nearly 25 different NGOs support this program.

## MATERNAL HEALTH



Data source: (IHME)

We can see the government relying on NGO CHWs again in the early 1990s, when it determined that less than five percent of deliveries occurred in a health facility and the maternal mortality ratio was over 500 deaths per 100,000 live births. The government responded by engaging UNFPA (United Nations Population Fund) to train over 50,000 traditional birth attendants (TBA) to perform safe deliveries and identify and refer complicated cases to midwives at sub-district hospitals as needed.<sup>4</sup> When, in the 2000s, it was clear that this was not enough, the government contracted with UNICEF and BRAC to train more than 50,000 of their own CHWs, primarily in northern Bangladesh.<sup>5</sup> Their mission was to improve antenatal care and skilled birth attendance rates by identifying pregnancies early, providing ANC services, and promoting skilled birth attendance.

ANC coverage increased from less than five percent in the early 1990s to more than 31 percent by 2014. Skilled birth attendance increased from 12 percent in 2000, to 46 percent in 2014.

**“THE NUMBER ONE REASON WHY BANGLADESH HAS DEVELOPED SUCCESSFUL COMMUNITY HEALTH EFFORTS IS BECAUSE OF THE NGO AND PRIVATE SECTOR’S FOCUS ON EXPERIMENTING AND INNOVATING—THIS TRIAL AND ERROR APPROACH HAS BEEN CRITICAL TO THE SUCCESS OF COMMUNITY HEALTH IN BANGLADESH.”**

—BILATERAL DEVELOPMENT FUNDER

## NGO-GOVERNMENT PARTNERSHIP APPROACHES

Approach	Description	Coordination Mechanisms
<i>Supplementary</i>	<ul style="list-style-type: none"> <li>» Government engages with one-two NGOs to address specific gaps in government service delivery</li> <li>» Enables government to quickly leverage NGO reach and capabilities to address limitations in service delivery</li> </ul>	<ul style="list-style-type: none"> <li>» These engagements often arise from forecasted limitations in government service delivery identified by the annual performance review process in the SWAp</li> <li>» NGOs and government create project implementation teams to coordinate and manage the work</li> <li>» Example: MSI sends nurses to hard-to-reach regions where there are high government nurse/physician vacancy rates, to provide contraceptives and to support government field workers to more effectively mobilize community members<sup>6</sup></li> </ul>
<i>Complementary</i>	<ul style="list-style-type: none"> <li>» Government partners with multiple NGOs to co-deliver basic services at scale</li> <li>» Extends and complements government service delivery on a long-term basis at national level</li> </ul>	<ul style="list-style-type: none"> <li>» Tasks and geographic intervention zones are identified through careful analysis of strengths and limitations and included in the partnership MOU</li> <li>» Government-led directorates manage coordination, monitoring and evaluation at multiple levels among the various NGO and government entities involved. NGOs place staff at the directorate</li> <li>» Example: NGOs were given defined tasks and geographic intervention zones in both the national EPI and tuberculosis programs<sup>3</sup></li> </ul>
<i>Contractual</i>	<ul style="list-style-type: none"> <li>» Government outsources public sector services to NGOs</li> <li>» Fills major gaps in government service delivery</li> </ul>	<ul style="list-style-type: none"> <li>» Project coordination and implementation units oversee the implementation of the partnership; include representation from donors, NGOs and government</li> <li>» Cross-sector steering committee provides high-level strategic oversight and policy guidance; includes representation from donors, NGOs and government</li> <li>» Contracts detail a standard set of services that NGOs agree to provide (aligned with the essential services package policy governed by the SWAp)</li> <li>» Example: The Urban Primary Health Care Project was initiated in 1997 to provide basic primary care services to the urban poor in Bangladesh</li> </ul>

In this way, Bangladesh developed a highly pluralistic CHW system. The government's network of CHWs and facilities, while on paper seemed comprehensive, in practice contained gaps and, as a result, was responsible for less than 20 percent of the curative services offered.<sup>7</sup>

NGOs have helped the government deliver that 20 percent of the curative services pie. In addition, NGOs have delivered their own services, often, but not, always to those not reached by the government programs.

The pluralistic system, with multiple channels of supplementary, complementary, and overlapping programming has sometimes been messy, but it has been effective in introducing a large portion of Bangladesh's population—especially women—to the national health system for the first time.

### **COORDINATING PARTNERS**

A broad range of NGO, private and informal providers play a critical role in Bangladesh's health system. One recent study found that the public sector is responsible for less than 20 percent of curative services.<sup>7</sup> To manage and coordinate all the complementary and supplemental programming, Bangladesh has instituted multiple levels of coordination across the CHW space:

- » At the local level, NGOs and government officials attend a monthly working group called the Upazila (sub-district) Health Council.
- » At the national level, the Sector-Wide Approach Health Nutrition Population Sector Program explicitly encourages the role of the private sector and NGOs in health care delivery, and more squarely put government in a policymaking and monitoring role. A range of national technical committees and working groups are part of the Sector-Wide Approach.

All of this leaves much room for NGOs to develop, scale, and innovate relatively unencumbered by government bureaucracies, often rife with barriers. It also leaves much room for duplicative programming.

### **CULTIVATING AND SUSTAINING POLITICAL COMMITMENT**

Political commitment is a nebulous concept. While it can be easily identified, deconstructing it to help inform policy and practice can be challenging.

In the case of Bangladesh, political commitment for CHW programming has been expressed in three key ways:

- » The declaration of support from high-level and influential leaders, who often used media campaigns to communicate their support.
- » Institutional commitment, both in the form of the inclusion of health care as a constitutional right, and prioritization of the CHW as a designated health care provider in policy documents.
- » The allocation of resources for CHW programming in government budgets.

Generating political will is a process that requires excellent timing. The political system is more open to new ideas during major political reforms, new administrations, or when crises occur.

Bangladesh's success demonstrates this dynamic. Supporters of CHW programming in Bangladesh elevated the urgency of health challenges that CHWs are particularly well-positioned to address—such as family planning and generating demand for immunization—during such policy windows. These periods included immediately after the country's founding, during changes in government, and during health crises. They promoted CHWs as a powerful and flexible tool to address the health challenge of the moment.

The first minister of health, for example, upon launching the CHW program to address family planning, stated:

**“AN ALL-OUT PREPARATION HAS BEEN MADE IN BANGLADESH TO MAKE IT [FAMILY PLANNING] A COMPLETE SUCCESS ON WAR FOOTING PREPARATION... IT IS UNIVERSALLY RECOGNIZED THAT THIS IS AN ESSENTIAL PRE-CONDITION NOT ONLY FOR THE PROSPERITY BUT FOR THE SURVIVAL OF THE NATION.”**

—FIRST MINISTER OF HEALTH<sup>8</sup>

BRAC, has also leveraged windows of opportunity to further support CHW programming. For example, during key national elections, BRAC together with the National TB programme, media, and stakeholders called on political parties to make specific pledges to increase CHW programming to reduce TB and incorporate these pledges into their platforms.<sup>9</sup>

The use of CHW programs to address crises and urgent health challenges further boosts support for them. The results and impact of high-profile campaigns can provide powerful evidence to evangelize the CHW approach and build a coalition of champions.

#### **INTEGRATION WITH THE WIDER HEALTH SYSTEM**

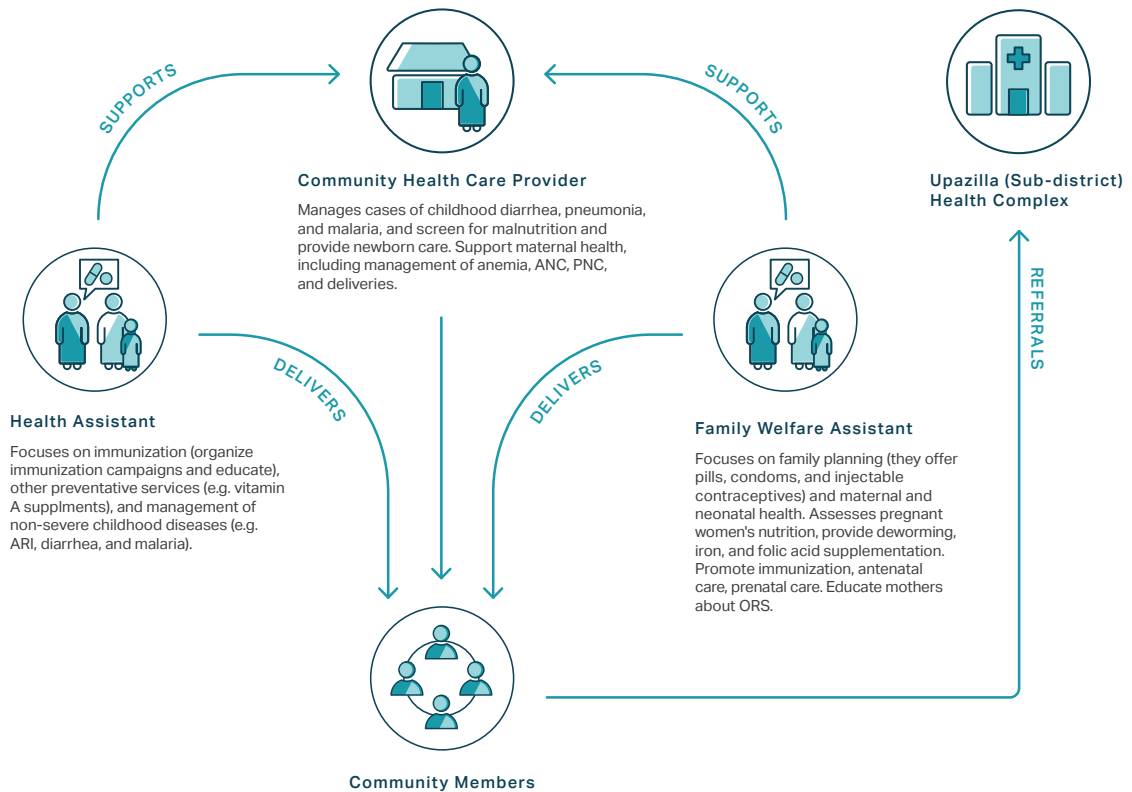
Bangladesh's government CHWs were, from the very beginning, paid civil servants meant to function as the most basic level of a diverse, but unified health system. They conduct household visits to promote health education, mobilize demand for and deliver basic curative services, and provide referrals for more complicated care in higher-level facilities.

In the early days of the CHW programming, CHWs provided all of this care in patients' homes or in community institutions such as mosques, schools, and even stores.

In 1998, the government constructed more than 13,000 community clinics to help reduce the outreach burden on government CHWs—ensuring CHWs spend less time traveling to patients and more time actually seeing patients. The clinics, a basic health facility that provides preventive, promotive and curative care, dispenses medicines, and provides referrals to upstream facilities, help ensure that only seriously ill patients, who need more sophisticated care, use the higher-level facilities. At the same time, by making essential health care more accessible, the clinics also serve to increase the number of seriously ill patients referred for care at higher-level facilities.

Today, eighty percent of the population is within a 30-minute walking distance of a community clinic.

## Government program overview



## COMMUNITY ENGAGEMENT

Bangladesh understood that for its CHWs to make an impact they would need to engage with the community in management, oversight, and cost-sharing to gain support. The country's 13,000 community clinics demonstrate one small way Bangladesh has secured community support and engagement.

Clinics are built on land donated by the community. Furthermore, in every community, groups comprised of local government representatives, CHWs, teachers in the local school, and residents, provide oversight of the community clinic's activities and are tasked with mobilizing the community to use the clinic's services. Critically, the Union Parishad member, an elected local government official of the community clinic's catchment area, plays a leadership role in the community group. The participation of such a high-ranking local official helps influence community members to support and use clinic services.

Further, while costs incurred for construction, medicine, service providers, logistics, and other inputs are borne by the government, each community clinic also maintains a bank account and attempts to raise funds from community members to defray general operating costs.

This ongoing community-government partnership is intended to ensure that the community feels vested in—and has some influence over—the community clinic and services it offers.

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## CHALLENGES

### KEY POINTS

- » Bangladesh's pluralistic system initially provided more robust and innovative care than the government alone could muster. But now, 40 years on, it is increasingly viewed as inefficient.
- » Inequity in access to health care remains.
- » Lack of standards can allow for poor quality of care.

Bangladesh's community health efforts have been impressive in their scope and ability to extend coverage of essential health services to poor rural populations. Of course, there have also been significant implementation challenges related to governance, human resources, and financing. The government of Bangladesh and NGOs are working to address these and other challenges, as detailed below:

### FRAGMENTATION AND DUPLICATION OF EFFORTS

Bangladesh's more laissez-faire policy environment and large NGO sector helped NGOs innovate and establish partnerships at scale. But it has also led to both fragmentation and significant inefficiencies. Perhaps the best example of this is the multiple CHW cadres, with overlapping service areas and baskets of services.

Realistically, this challenge can only be fully resolved by something Bangladesh has avoided over all these years: a unified national CHW strategy.

Ironically, the government has turned, once again, to NGOs for assistance in developing this strategy to better manage NGOs, harmonize CHW job descriptions, and strengthening standards in training, definitions, and care.<sup>1</sup> Save the Children, USAID, and UNICEF are leading this work, which began in 2016.<sup>2</sup>

### **"PLURALISM HAS BEEN HELPFUL, BUT WE HAVE NOW COME TO A POINT WHERE WE NEED MORE STREAMLINED AND HIGH-PERFORMING SERVICES."**

—BRAC OFFICIAL

The Bangladesh Medical Association and the Ministry of Health and Family Welfare, DGHS, and DGFP have formed a committee to recommend how to align roles and responsibilities.

It is important to note that fragmentation and varying skill levels and services of each CHW cadre also impacts patient care. CHWs' training, function, and ability vary widely depending upon the organization they work for. So, if a BRAC CHW is not available, it is not always an equal value for a patient to seek out the next available CHW, who perhaps offers entirely different services and provides a different level of care. This uncertainty can lead to inconsistent and poor care, and undermine confidence in CHWs as a whole.

### **INCONSISTENT AND INCOMPATIBLE DATA COLLECTION**

The two Directorates who lead CHW programming, the Directorate General of Family Planning and the Directorate General of Health, as well as each private sector partner and NGO, each collect different data, from different sources, on different schedules. They store and manage that data in unique ways, creating a patchwork of systems that stops short of providing the sort of clear and actionable information that policymakers need.

To address this, Bangladesh and its partners are working to establish a culture of routine and clear data collection standards. Toward this end, Bangladesh plans to develop a fully digital health system, meaning all patient information collected by government CHWs will be on a national database by 2021.<sup>3</sup> Already, all community clinics have a functional laptop computer (and internet) in which staff enter routine health information data, such as the numbers of patients treated and summary statistics on maternal health, childhood illnesses, accidents, and nutrition, in a standard manner.<sup>4</sup> Even CHWs at community clinics are beginning to use electronic records that pull from and feed into this national system. In addition, all facilities are now required to enter data into an online dashboard that monitors performance at all facility levels, including community clinics. At the end of the year, “local health bulletins” are created to report on progress and these are also used to recognize certain community clinics for exceptional performance.<sup>5</sup>

### **CHW VACANCIES AND ABSENTEEISM**

Government CHW programs suffer from high vacancies and absenteeism. Approximately 15 percent of government CHW positions are vacant at any given time, and anecdotal evidence suggests absenteeism rates are exceedingly high.<sup>6</sup> Even with the use of female CHWs, which reduces turnover, retention is cited as a major problem for government and BRAC workers, especially in hard-to-reach areas.<sup>7</sup>

Turnover increases training costs, reduces quality of care, and strains the workload of the remaining CHWs.

To address this, the government is prioritizing improved recruitment and retention strategies. A revised human resource for health (HRH) plan under development will “ensure adequate number of personnel with appropriate skill mix, deployment with terms and conditions, retention, career progression, job satisfaction, etc.”<sup>8</sup>

Likewise, BRAC’s program struggles with dropout rates of 5-10% annually among Shasthya Kormis, and 10–15% annually among Shasthya Shebikas.<sup>9</sup> This turnover significantly undermines the organization’s goal of sustainable programming. The organization has reduced the number of CHWs to reduce competition between CHWs and increase their earning potential.

### **BUREAUCRACY AND GOVERNANCE**

The government’s CHW programming suffers from bureaucratic and slow decision-making. For example, establishing a new CHW post requires approval from six ministries and institutional entities, and can take as long as three years.<sup>10</sup> Moreover, key components of CHW programming, like recruitment, retention, and management, fall under the purview of a variety of ministries.

At the same time, there are significant gaps in government oversight of NGO CHW programming. For example, there are currently no minimum standards or training guidelines for NGO CHW cadres. Save the Children, UNICEF, USAID and others are partnering with the government to develop those standards and guidelines.

### QUALITY CONTROL

A 2002 study found that the vast majority of government CHWs did not have the necessary skills to deliver the essential service package, and the majority of clinics lacked the appropriate equipment and drugs.<sup>10</sup> Such deficiencies undermine confidence in the CHW cadres.

To strengthen accountability and supervision structures at the community level, the government has begun to provide all government CHWs with tablet computers. The tablets allow the supervisor to regularly communicate with CHWs, and approve and monitor progress on their workplan.<sup>5</sup> The tablets come preloaded with e-learning toolkits, including videos demonstrating common scenarios and best practices for diagnosis and counseling. These courses, developed by the government, can be viewed offline to help support CHWs' learning and improve professionalism.<sup>11</sup> However, ensuring proper and consistent use of the tablets can be challenging, given the minimal education level of some CHW cadres.

In addition, community groups that help manage the clinic have been tasked with addressing performance issues. These community groups, however, cannot ensure timely delivery of medicines to their local clinic, nor can they arrange supplementary training for any staff whose skills are insufficient.

### VILLAGE DOCTORS

Most health care in rural Bangladesh is provided by personnel known as "village doctors." A 2007 study found that only four percent of these "doctors" had any government training.<sup>12</sup> Another 2007 study of village doctors in Chakaria found that many of them engage in inappropriate and harmful practices.<sup>13</sup> Why do sick people consult them if they do harm? Often, it is a question of availability and cost. At the time of the study, for example, Chakaria had only 39 formally trained doctors instead of the 250 necessary to adequately serve the administrative region's population of half a million. Where formal medical doctors are not available, village doctors thrive. Further, many village doctors provide their care on credit.<sup>12</sup>

### INEQUITY

Health inequities across wealth quintiles and across geographies remain and are particularly large when it comes to rates of institutional delivery and immunization rates. Inequity in rates for under-five mortality across wealth quintiles has been falling. However, inequity between rural and urban areas for under-five mortality remain. The under-five mortality rate in urban areas is twenty-four percent less than in rural areas, and the infant mortality rate is two times higher in the lowest income quintile than it is in the highest income quintiles.<sup>14</sup>

## Under-five mortality rate and health indicators by wealth quintile

(1993–2014)

### Demand for family planning satisfied

by wealth quintile

### Full immunization

by wealth quintile

### Institutional delivery

by wealth quintile

### Child mortality

by wealth quintile



While there has been an improvement in health indicators, inequities among wealth quintiles remain.

Data source: DHS Surveys; Analysis: International Center for Equity in Health, Federal University of Pelotas, Brazil

### REDUCED DONOR SUPPORT

Overall international donor support to the health sector (not limited to the Sector-Wide Approach) has been steadily decreasing as a share of the Ministry of Health and Family Welfare (MOHFW) budget. From a peak of over 40 percent of the budget in 2001, international donor support had fallen to about half that share by 2015.<sup>15</sup>

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## CONTEXT

### BANGLADESH'S FIRST 15 YEARS AFTER GAINING INDEPENDENCE FROM PAKISTAN IN 1972

were marked by a series of military coups, countercoups, and political assassinations. These challenges were coupled with frequent natural disasters. Seasonal flooding and destructive cyclones regularly laid waste to large portions of the country. This undermined food security, poverty alleviation, and agricultural development efforts, and increased demand for health care while reducing the country's ability to deliver it.

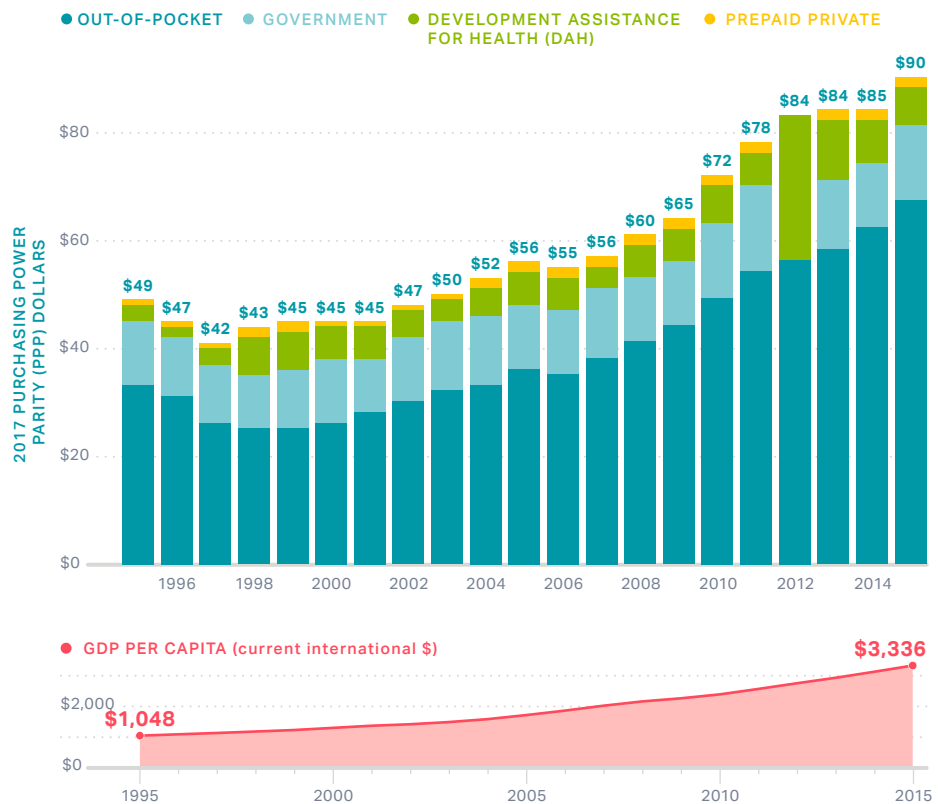
As Bangladesh's political crises have become less frequent over the last two decades, and agricultural production has improved, the country has experienced improved economic growth. The agricultural sector still provides employment for a majority of Bangladeshis, but more than three million people—80 percent of them women<sup>1</sup>—now work in the growing textile sector.<sup>2</sup> The country exports more than \$30 billion worth of clothing a year. Annual GDP growth rates have been in excess of five percent since 2003. This economic growth has sparked a cultural, economic, and health transformation.<sup>3</sup>

Bangladesh is expected to become a middle-income country by 2021, though 24 percent of the population still lives below the international poverty line of less than \$1.90 a day.<sup>4</sup> With this economic growth, the country has seen a decline in infectious diseases and a rapid increase in non-communicable chronic diseases in an increasingly urban and aging population.<sup>5</sup>

Despite this economic growth, Bangladesh's level of health expenditure remains low, just \$90 per capita. That is the lowest in South Asia, less than half the South Asian average of \$210 per capita, and close to the level found in much lower income countries such as Benin and Burkina Faso.<sup>6</sup>

Given the limited public sector expenditure on health care and openness to external partners, international funding has played a key role in the development of Bangladesh's community health efforts. From 1995–2015, development assistance for health increased from roughly \$2–3 per person to \$7–8 per person. In 2015, Bangladesh's development assistance for health was nearly double the South Asia average of \$4 per person.<sup>6</sup> Today, Bangladesh is the fifth highest recipient of total foreign development assistance for maternal, newborn, and child health (MNCH) programs, and the fourth largest recipient for tuberculosis (TB) programs in the world. The delivery of both MNCH care and TB treatment rely heavily on CHWs.<sup>7</sup>

### Health expenditure in Bangladesh



Data source: Institute for Health Metrics and Evaluation (IHME); World Bank

There are a few characteristics of Bangladesh that make community health worker programming appropriate. These include the country's extremely low health workforce (7.4 skilled health workers per 10,000 population in 2015—a fraction of the WHO's recommended minimum of 23 per 10,000) and its rural character (an estimated 64 percent of Bangladesh's 164 million citizens live in rural areas, far from health facilities).<sup>8,9</sup>

It is also worth noting that Bangladesh has an estimated 500,000 informal private sector health providers, the majority of whom are untrained and unregulated. Despite this, they provide a large portion of rural residents with health care. (More on these providers can be found in the Challenges section.)

### RESEARCH AND LEARNING

The government of Bangladesh has benefited from one of the developing world's most comprehensive, detailed, and longest-running longitudinal data resources maintained by icddr,b (founded as the International Centre for Diarrhoeal Disease Research, Bangladesh). In 1963, the organization established a field diarrhea hospital and surveillance system known as the Matlab Health and Demographic Surveillance System (HDSS), in Matlab, Chandpur (then, East Pakistan). Initially, the site evaluated cholera vaccines and oral rehydration therapy, and studied the epidemiology, prevention, and treatment of diarrheal diseases. The mission of the research program quickly expanded beyond diarrhea, and Matlab became a testing ground in which icddr,b and its many partners, tried innovative approaches to improving health care broadly, with an eye toward scaling across the country.

For more than 50 years, Matlab researchers have been collecting detailed demographic information. This includes visiting more than 200,000 households across 142 villages regularly to record data on births, deaths, illnesses, health care, education, marriages, and migration. This wealth of data on the health and health-seeking behavior of the local population, which icddr,b has shared with the government, other NGOs, and international researchers, has provided a clear understanding of health challenges and changes. It has profoundly informed and influenced Bangladesh's CHW programs and policies.

**“THIS ARRAY OF INTERRELATED INFORMATION IS INVALUABLE IN A COUNTRY THAT HAS NO NATIONWIDE REGISTRATION SYSTEMS AND SCANT RESOURCES TO DEVELOP HEALTH INFORMATION SYSTEMS AND MONITOR TRENDS IN THE NATION'S HEALTH.”**

—ICDDR,B INFORMANT<sup>10</sup>

icddr,b's Matlab helped the government develop its initial CHW family planning program in the 1970s. And when Matlab's research demonstrated that 63 percent of childhood deaths in Bangladesh were due to vaccine-preventable disease, the government launched immunization campaigns spearheaded by CHWs.<sup>10</sup>

Connecting the research community with practitioners and policy makers to disseminate evidence has been as important as establishing Matlab's research infrastructure. The National Institute for Population Research and Training (NIPORT), established by the Ministry of Health and Family Welfare (MOHFW) in 1977, serves as a key linkage in this respect. NIPORT is an autonomous research institute which conducts public health surveys (e.g., demographic health surveys, maternal mortality survey, health facilities surveys, etc.) and implementation science studies, and then disseminates learning from these studies to a broad range of government and NGO stakeholders. The hope is that these leaders then use presented learnings to make changes to existing program or design new programs to address new gaps and challenges.

For example, data from the 2014 Demographic and Health Survey showed the total fertility rate was much higher in Sylhet and Chittagong than in other divisions. NIPORT shared this finding with the Directorate General of Family Planning through a series of national consultations. The ministry then advocated for additional NGO-contracted CHWs to work in these areas and provide information about and access to modern contraceptives.

NIPORT also ensures that information gained through research helps shape the country's public health research agenda and is factored into the training of government health workers who provide family planning services, including FWAs. BRAC also has a robust Research and Evaluation Division (RED) that includes a multidisciplinary independent research unit. The division plays an important role in designing BRAC's interventions, monitoring the progress of those interventions, and identifying gaps. BRAC, like icddr, and other partners, has shared its research and data with government to ensure policies and programs are evidence-based and effective.

### **SUPPORTIVE POLICY ENVIRONMENT FOR NGOS**

Compared to other countries in the region, such as India and Pakistan, public policy in Bangladesh has been unusually successful in balancing the need for official oversight on NGOs, with the need to provide NGOs with the operational autonomy necessary for experimentation and innovation.<sup>5</sup>

The absence of heavy-handed constraints on the NGO sector by the government of Bangladesh has been cited as a key reason why the sector has grown more rapidly in Bangladesh than in other countries.<sup>11</sup>

Bangladesh's government regulatory architecture is simple: the NGO Affairs Bureau, housed within the prime minister's office, regulates all NGO activity in Bangladesh.<sup>12</sup> In many other countries, including neighboring India and Pakistan, NGOs must navigate multiple layers of government bureaucracy.<sup>11</sup>

Bangladesh does not just take a laissez-faire attitude toward NGOs. It has also adopted policies that recognize a robust role for NGOs within the health system. This is made clear by the 1998 Essential Health Services Package (ESP) and the first Sector-Wide Approach which formally recognized that NGOs and the private sector were indispensable to delivering essential health services to the rural and urban poor.<sup>13</sup> The fifth Five-Year Plan (1997–2002), the first Sector-Wide Approach (1998) and the National Health Policy (2000) also explicitly encouraged the private sector and NGOs to assist the government in health care delivery and more squarely put government in a policy-making and monitoring role.<sup>14</sup> The first Sector-Wide Approach included the following statement:

**“INVOLVEMENT OF THE PRIVATE SECTOR AND NGOS WILL BE PROMOTED WITH A VIEW TO ACHIEVING THE SPIRIT OF PARTICIPATION AND OWNERSHIP IN HEALTH DEVELOPMENT .... THE ROLE OF GOVERNMENT WILL BE LIMITED TO POLICY SETTING, MONITORING AND CONTROL.”**

—STATEMENT FROM FIRST SECTOR-WIDE APPROACH<sup>15</sup>

This broad policy declaration prompted two key shifts in NGO-government partnerships in the late 1990s:

- » The government transitioned from being a provider of services toward being a purchaser of services—contracting with NGOs for CHWs. In such arrangements, NGOs competitively bid for government contracts to provide CHW services in defined catchment areas. These contracts generally require partner NGOs to provide 30 percent of their services for free to the poor, ultra-poor, and at-risk populations—ensuring that partners retain the government's focus on reducing inequity.
- » A range of national technical committees and working groups in the health sector were established to help improve coordination of an increasingly pluralistic system at national level.

In this supportive policy environment, public-private partnerships thrived.

### **ROBUST NGO SECTOR**

While other countries may have comparably large NGO sectors, Bangladesh is remarkable in that it is home to multiple national indigenous NGOs which enjoy deep community engagement, diversity in service delivery, and institutional and research sophistication. Indeed, NGOs like BRAC and Grameen are similar to governments in terms of their reach and complexity. Their significant and nuanced understanding of the local context, and strong and deep partnerships with village organizations, increases both the appropriateness and acceptability of their current role as leaders of national community health systems.

The country is also home to offices from many of the world's largest international NGOs. Between local and international organizations, very little of the country remains untouched by NGOs. One 2000 study found that more than 90 percent of rural communities had some NGO presence.<sup>16</sup>

The origins of Bangladesh's robust NGO sector can be traced back to the liberation war in 1971 and famine shortly thereafter. Given the country's immense health challenges at the time, the new government's limitations, and the need for broad investment in the country's development, government leaders implemented a supportive policy environment toward NGOs. They were eager to allow the establishment and rapid growth of local NGOs that could help them problem-solve and develop the country.

Furthermore, during the challenging early days of the country's history, civil society leaders were often viewed by the government as important allies. Likewise, these civil society leaders saw their role as serving Bangladesh alongside the government. NGO leaders established friendships with top government officials and developed parallel service delivery mechanisms which have grown with the government's help. These indigenous NGOs have consistently taken a consultative approach to working with the government and, recognizing government limitations, have helped drive significant experimentation and innovation, delivering services when and where the government cannot.

**"WE ARE ALWAYS TRYING TO COMMUNICATE WITH THE GOVERNMENT. WE, AS NGOS, ARE ALWAYS THINKING ABOUT HOW WE CAN COMPLEMENT GOVERNMENT, HOW WE CAN SHARE OUR WORK AND MOVE FORWARD TOGETHER."**

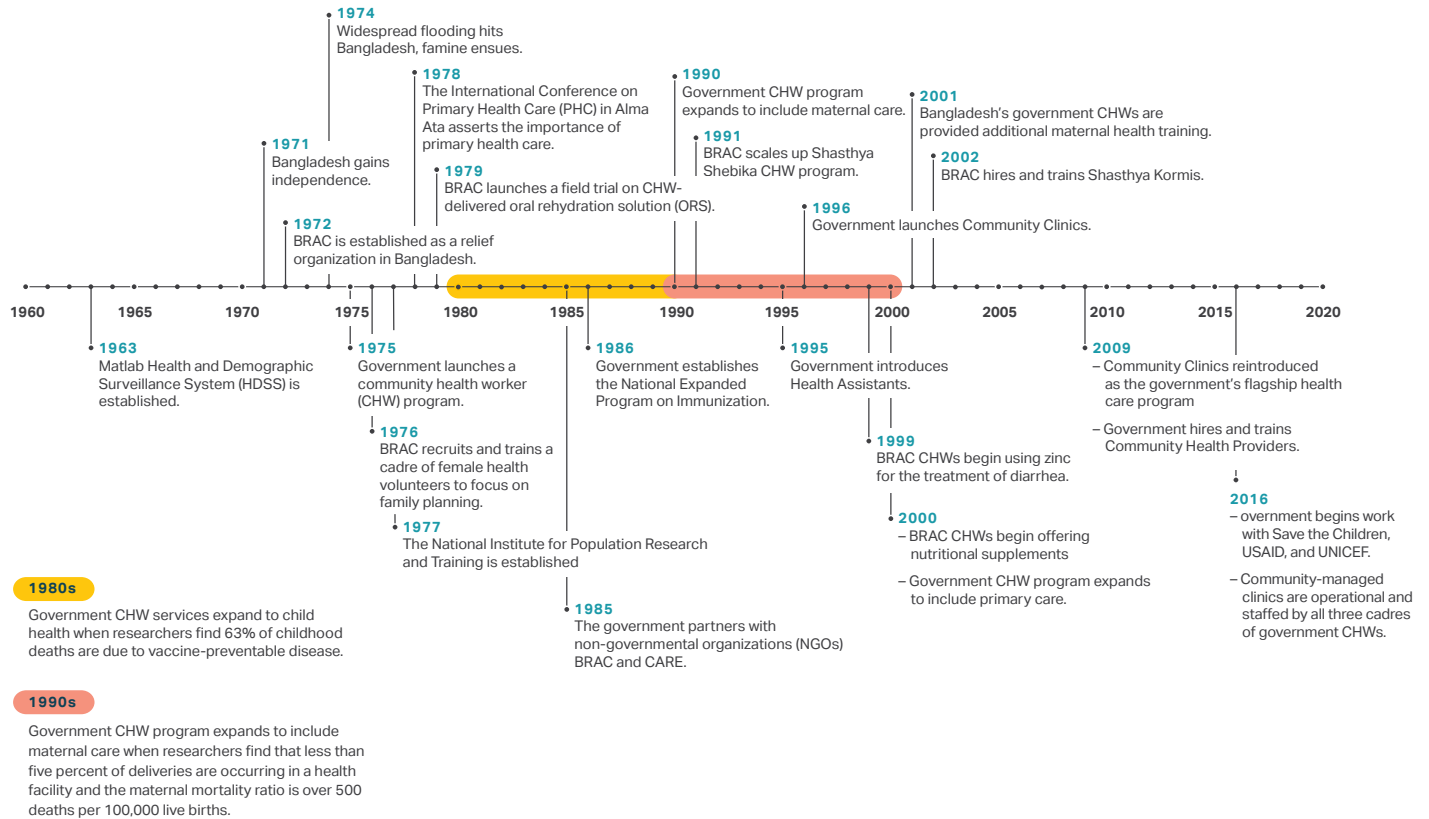
—NGO LEADER<sup>17</sup>

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## MILESTONES

### Timeline of key events



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## METHODOLOGY

### RESEARCH APPROACH

#### Overview

This Exemplar narrative sought to address the following research question: What are the key factors that enabled the expansion and effectiveness of Bangladesh's CHW program? Two frameworks were used to broadly organize the research and analysis: WHO ExpandNet<sup>1</sup> and Primary Health Care Performance Initiative (PHCPI).<sup>2</sup> The WHO ExpandNet framework guided a systematic exploration of the scaling up process of Bangladesh's CHW program. The PHCPI framework organized the inquiry of program design and the health system along the lines of governance and leadership, health care workforce, health financing, facility infrastructure, and service delivery. Contextual factors that influenced CHW program expansion, including political, social and economic, were considered throughout this process.

#### Advisory Panel

Last Mile Health assembled a seven-member Technical Advisory Panel of global community health and primary health experts. The Panel selected Exemplar countries and advised on the research methods described below and the country narrative content.

#### Research Partner

In Bangladesh, Last Mile Health partnered with BRAC who supported the identification of key documents and stakeholders and provided critical input to the country narratives.

### METHODS

#### Literature Review

To answer our research question, Last Mile Health conducted a review of more than 100 documents to develop this country narrative. Documents selected focused on the design and impact of the program and contextual factors which influenced program expansion. Documents included peer-reviewed journal articles, published reports, impact evaluations, government and NGO strategy and policy documents, meeting presentations, and other public and private documentation shared by stakeholders who participated in the CHW program design and implementation process. Last Mile Health also analyzed publicly available health financing, coverage and outcome data from demographic health surveys, annual government reporting and other globally recognized data sets such as the Institute for Health Metrics Evaluation, the World Bank, and the WHO.

### Interviews

Last Mile Health conducted semi-structured interviews with 30 key stakeholders in Bangladesh to obtain additional context regarding the evolution of the community health efforts. Findings from the literature review informed the development of interview guides. The guides included questions about the following topics: program inception, program evolution, success factors, outstanding challenges, and future vision. Furthermore, the guide was tailored to the local context as required. Interviewees were selected through purposive and snowball sampling and included both current and former Ministry of Health and Family Welfare (MOHFW) leaders, including the Directorate of Family Planning (DGFP) and Directorate of Health Service (DGHS), and professional associations, research institutions, international and domestic NGOs, as well as multilateral and bilateral institutions. Many of the interviewees played a leadership role in the evolution of Bangladesh's community health programming. When possible, interviews were recorded and transcribed.

### Analysis

Last Mile Health's research team analyzed the transcripts using a thematic approach and in alignment with the topical areas included in the interview guides. Findings from the interviews were supplemented with additional literature review. Using inductive reasoning, Last Mile Health explored key factors that contributed to the successful scale-up and implementation of Bangladesh's community health programming. Last Mile Health followed up with many of the original interviewees to ensure accuracy of the analysis and validity of the findings

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