WORKING WITH INDIVIDUALS, FAMILIES AND COMMUNITIES (IFC) TO IMPROVE MATERNAL AND NEWBORN HEALTH PROGRAMME (2019 – 2024)

• 2025 •

Documentation of Lessons Learned and Identification of Future Interventions

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Final Report

THINKTHROUGH CONSULTING
connecting ideas for impact

Study Team

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Acronyms

ACP	Active Citizen Participation
ANC	Antenatal Care
BHE	Bureau of Health Education
BHP	BRAC Health Program
BRAC	Bangladesh Rural Advancement Committee
BMRC	Bangladesh Medical Research Council
CAG	Community Action Group
CBHC	Community-Based Health Care
CC	Community Clinic
CCHST	Community Clinic Health Support Trust
CG	Community Group
CHCP	Community Health Care Provider
CHW	Community Health Worker
CSG	Community Support Group
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DPP	Development Project Proforma
ECD	Early Childhood Development
EdM	Enfants du Monde
FGD	Focus Group Discussion
FMC	Facility Management Committee
FP	Family Planning
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GRS	Grievance Redress System
HNPP	Health, Nutrition and Population Programme
HPNSP	Health, Population and Nutrition Sector Programme
HSD	Health Services Division
IFC	Individuals, Families, and Communities
KII	Key Informant Interview
LGI	Local Government Institute
LGSP	Local Government Support Project
LMIC	Low and Middle Income Country
MEFWD	Medical Education and Family Welfare Division
MNH	Maternal and Newborn Health
MNCH	Maternal, Newborn, and Child Health
MMR	Maternal Mortality Ratio
MOHFW	Ministry of Health and Family Welfare
NIPORT	National Institute of Population Research and Training
NMR	Neonatal Mortality Rate
PNC	Postnatal Care
PO	Programme Organizer
RMC	Respectful Maternity Care
SDG	Sustainable Development Goal
SK	Shasthya Kormi
U5MR	Under-Five Mortality Rate
UH&FWC	Union Health and Family Welfare Center
UHFPO	Upazila Health and Family Planning Office
UP	Union Parishad
WHO	World Health Organization

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1.Background of the Study

Maternal and newborn mortality remains a significant global health challenge, with approximately 287,000 maternal deaths and 2.3 million neonatal deaths reported in 2020/2022, predominantly in low- and middle-income countries (LMICs).[1] Most of these deaths are preventable through timely access to skilled care during pregnancy, childbirth, and the postnatal period. Key causes include postpartum hemorrhage, infections, hypertensive disorders, and neonatal complications such as preterm birth and sepsis. Social determinants, including poverty, gender inequality, and limited healthcare access, exacerbate these challenges, particularly in rural areas[1].Despite substantial progress in improving maternal, neonatal, and child health (MNCH) over the past decades, Bangladesh continues to face significant challenges in achieving the Sustainable Development Goals (SDGs) related to maternal and child survival. The country has made notable advancements, particularly in reducing maternal mortality. The maternal mortality ratio (MMR) decreased from 322 per 100,000 live births in 2001 to 194 per 100,000 live births by 2010, driven by improvements in healthcare access, care-seeking behaviors, and indirect factors such as education and women's empowerment[2] .Similarly, child health indicators, including the under-five mortality rate (U5MR), have shown progress. However, these positive trends have slowed in recent years, revealing that challenges remain deeply entrenched in the healthcare system. As of 2016, the MMR has stagnated at 196 per 100,000 live births, well above the SDG target of 70 per 100,000 live births by 2030 [3].Neonatal mortality continues to represent a significant burden, with neonatal deaths accounting for 67% of all under-five deaths. The neonatal mortality rate (NMR) has remained largely unchanged at 15 per 1,000 live births, highlighting the need for focused interventions in neonatal care [4].The country also has the highest stillbirth rate in the region, at 25.4 per 1,000 live births, underscoring the poor quality of intrapartum care [4].

Access to quality care remains uneven in Bangladesh, with only 41% of women receiving four or more antenatal care (ANC) visits in 2022, down from 46% in 2017–18, and just 55% accessing postnatal care (PNC) from a medically trained provider within two days of delivery. While facility births increased to 65% in 2022 from 51% in 2017–18, the cesarean section rate surged to 45%, indicating both improved access and potential overuse[5]. These gaps underscore the need for a continuum of care that ensures the highest attainable health standard from adolescence through pregnancy, childbirth, and the postnatal period, across households, communities, and health facilities. No single intervention can suffice; comprehensive, community-driven strategies are essential to reduce mortality and morbidity[6]. The slow reduction in maternal and neonatal mortality rates highlights the importance of a holistic approach, emphasizing a broad range of interventions and services at various levels of the health system.

As Dr. Mahmood Fathalla famously stated,

> ***"Women are not dying because of diseases we cannot treat; they are dying because societies have yet to make the decision that their lives are worth saving"***

[1] World Health Organization. (2024). Maternal and Newborn Health: Key Facts. Available at: https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
[2] National Institute of Population Research and Training (NIPORT). (2016). *Bangladesh Maternal Mortality and Health Care Survey 2016 (BMMS 2016)*. Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh.
[3] Ministry of Health and Family Welfare (MOHFW). (2020). *The 4th Health, Population and Nutrition Sector Programme (HPNSP) Report*. Government of Bangladesh.
[4] Bangladesh Bureau of Statistics (BBS). (2020). *Sample Vital Registration System (SVRS) 2020*. Government of Bangladesh.
[5] National Institute of Population Research and Training (NIPORT). (2022). *Bangladesh Demographic and Health Survey 2022: Key Indicators Report*. Dhaka, Bangladesh: NIPORT.
[6] Kerber, K. J., de Graft-Johnson, J. E., Bhutta, Z. A., Okong, P., Starrs, A., & Lawn, J. E. (2007). Continuum of care for maternal, newborn, and child health: From slogan to service delivery. *The Lancet*, 370(9595), 1358–1369. https://doi.org/10.1016/S0140-6736(07)61578-5

This emphasizes the critical role of collaboration and community involvement in improving maternal and neonatal health and achieving long-term health improvements.[7]

In response, the *Individuals, Families, and Communities (IFC)* programme, a collaborative effort between Enfants du Monde (EdM) and BRAC, is transforming the landscape of maternal and newborn health in Bangladesh. Launched in 2019 in the Sarail and Kasba upazilas of Brahmanbaria, this initiative builds on EdM's long-standing MNH efforts since 2008 and BRAC's extensive community health network. Funded by EdM and implemented through BRAC's Health Programme (BHP), the IFC programme is grounded in the WHO's IFC framework and the 1986 Ottawa Charter on Health Promotion, which emphasizes the importance of collaboration with individuals, families, and communities to ensure effective, sustainable health interventions[8].

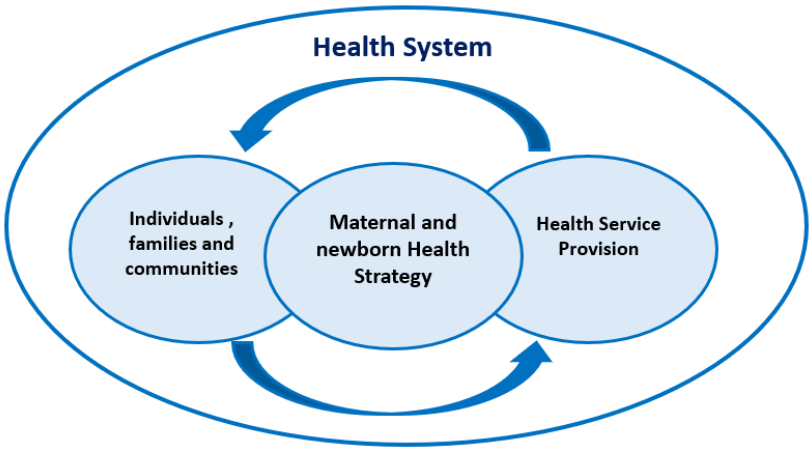


Figure 1.1: Individuals, families and communities within the health system[8]

The 2021–2024 phase of the IFC programme aims to enhance MNH by incorporating several key components. These include training Community Health Workers (CHWs) from BRAC and MOHFW in health education, with a focus on rights and Early Childhood Development (ECD); providing training to managers and healthcare providers on health promotion and demand creation for maternal, newborn, and child health (MNCH) services; educating women and communities on MNH; and fostering community participation through care assessments. These activities are aligned with BRAC's Health Programme (formerly HNPP) and contribute to the objectives of the Health Population and Nutrition Sector Development Plan (HPNSP) of MOHFW.

[7] Fathalla, M.F., Global trends in women's health. International Journal of Gynecology & Obstetrics, 1997 58(1): p. 5 - 11.
[8] BRAC & Enfants du Monde (EdM). (2024). *Terms of Reference: Working with Individuals, Families, and Communities (IFC) to Improve Maternal and Newborn Health Programme (2019–2024)*. Internal Programme Documentation.

Figure 1.2: Activities of the project

The IFC programme is structured around four core pillars: (1) training community health workers (CHWs), including Shasthya Kormis, on health education, rights, and early childhood development (ECD); (2) equipping healthcare managers and providers with skills in health promotion; (3) generating demand for MNCH services; and (4) promoting community participation in care assessments. The programme has empowered vulnerable populations by engaging them in health decision-making processes and providing the necessary tools and knowledge to improve maternal and child health outcomes [8]. During the pilot phase from 2019-2020, the project trained CHWs and mobilized Community Action Groups, engaging members of Community Groups and committee members in the targeted areas . The 2021-2024 phase further integrated ECD, aligning with BRAC's long-term vision for 2030, strengthen community capacities and health system linkages, ultimately increasing access to and utilization of health services in rural areas

Empirical evidence demonstrates that empowering families and shifting gender norms through the IFC approach have led to increased skilled birth attendance and higher rates of facility-based deliveries, making this model cornerstone for sustainable MNH progress in Bangladesh [9] [10]. The success of community clinics in rural areas, which provide accessible, trusted care and foster community participation, further underscores the effectiveness of the IFC approach in ensuring that more women seek and utilize maternal health services 8.

This report presents comprehensive documentation and analysis of the lessons learned from the Individuals, Families, and Communities (IFC) programme, which has been implemented by BRAC in collaboration with Enfants du Monde (EdM). It critically examines the successes, challenges, and key interventions of the programme since its inception, assessing their potential for integration into Bangladesh's public health system. The report highlights best practices and explores opportunities for future project collaborations and health promotion initiatives for maternal and newborn health (MNH) in partnership with relevant stakeholders and donors. The overall objective of this report is to reflect on the impactful interventions of the IFC programme, determining which aspects can be integrated into the national health system, which should be excluded, and identifying areas where support from other stakeholders may be crucial. Additionally, the report opens the door for new opportunities for collaboration between EdM, BRAC, and other partners to strengthen health promotion efforts for MNH in Bangladesh.

[9] Taleb, F., Perkins, J., Ali, N. A., et al. (2015). Transforming maternal and newborn health social norms and practices in Bangladesh. *Global Public Health*, 10(5–6), 570–582. https://doi.org/10.1080/17441692.2014.991429

[10] Rahman, A., Leppard, M., Rashid, S., Jahan, N., & Nasreen, H. E. (2018). Community perceptions of behaviour change communication interventions in Bangladesh. *BMC Public Health*, 18(1), 1–10. https://doi.org/10.1186/s12889-018-5103-0

2. Methodology

The methodology for this study employs a qualitative-based mixed-methods approach to thoroughly assess the IFC programme (2019–2024), focusing on the documentation of lessons learned, identification of best practices, and the formulation of future interventions for maternal and newborn health (MNH) in Bangladesh. This approach combines primary qualitative data from diverse stakeholders with an extensive secondary literature review, ensuring a comprehensive understanding of the programme's impact, challenges, and its potential for integration into the national health system.

The study utilizes a rigorous secondary literature review to contextualize the findings within the broader MNH landscape, providing valuable background and comparison to other similar initiatives. The qualitative research approach was carefully selected due to its ability to explore the complex, context-specific issues related to MNH interventions, where social, cultural, and systemic factors significantly influence outcomes. This methodology allows for a deep examination of the experiences, perceptions, and insights of key stakeholders involved in the programme, including health workers, programme managers, and government officials.

The study followed a participatory methodology, collecting both primary and secondary data to ensure a well-rounded assessment. Secondary data were gathered through a comprehensive literature review, while primary data were collected via Key Informant Interviews (KIIs). The primary respondents included personnel from Enfants du Monde (EdM) both at the headquarters and field levels, as well as Community Health Workers (CHWs) from government, sub-district health and family planning (FP) officials, local government representatives (LGI), and members of the community. Field data collection focused on the sub-district Sarail, in Brahmanbaria district. Data collection for the study continued from 07 to 09 May 2025.

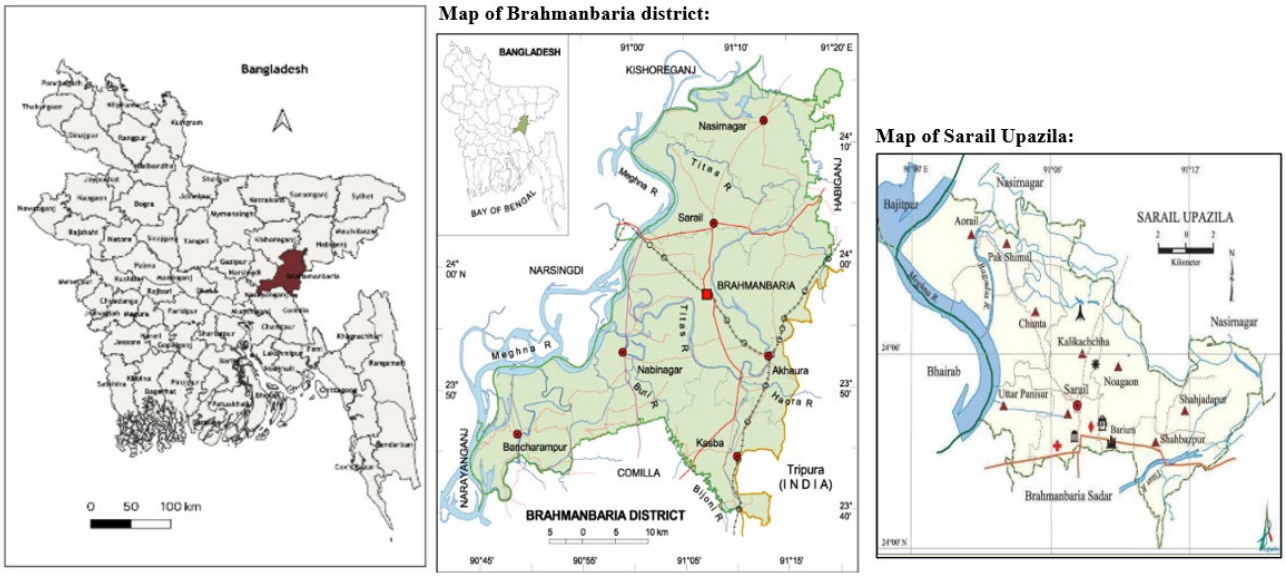


Figure 2.1: Study Area

A total of **12 KIIs** and **4 FGDs** were conducted, ensuring a comprehensive assessment of the programme's various components. The table below outlines the specific respondents and the number of interactions:

Respondents	Mode of Interaction	No. of Interactions
Senior representative and leadership team members from EdM and BRAC HNPP	KII	2
Senior officials from DGHS and DGFP,	KII	2
Civil Surgeon, UHFPO	KII	2
Frontline Health Worker (CHCP and FWA/FWV)	KII	4
CG, CSG, CAG (FGD)	FGD	4 (24 Person)
Relevant health system experts of Bangladesh	KII	2
Total	**KII**	**12**
	FGD	**4**

Table 1: Number of Respondents in KIIs and FGDs

The KIIs focused on gathering in-depth perspectives from stakeholders with significant roles in the programme's design, implementation, and oversight. The FGDs, on the other hand, were conducted with community groups involved in the programme to gain insights into the direct impact of the interventions on beneficiaries. The sampling strategy used for selecting participants was based on **purposive sampling** and **snowball sampling** techniques. These methods were chosen to ensure that the selected respondents were directly involved with the programme and could provide in-depth insights into the programme's implementation, outcomes, and potential for scaling. This combination of methods ensured that the study captured both high-level strategic perspectives and ground-level experiences, providing a holistic view of the programme's effectiveness.

2.1 Secondary Literature Review

The secondary literature review serves as a foundation for the evaluation, ensuring that the study is informed by existing data and insights. This review involved analyzing a wide array of project-related documents, including baseline and endline reports, training manuals, evaluation reports, and monitoring data. These documents provided valuable context for understanding the programme's design, implementation, and outcomes, and helped identify trends and patterns that would guide the primary data collection process.

The following specific documents reviewed in the process:

- ✓ **Project proposal**
- ✓ **Approved M&E plan**
- ✓ **Approved work plan of each year**
- ✓ **Baseline report of the EdM programme with BRAC by BRAC JPGSPH**
- ✓ **Draft Endline valuation Report**
- ✓ **Periodic M&E data and reports**
- ✓ **ACP Documentation**
- ✓ **Case studies and testimonials**
- ✓ **Annual review and training reports of the programme by BRAC**
- ✓ **Relevant reports & research papers available**

Table 2: List of Documents for Secondary Literature Review

2.2 Data Analysis

Secondary Data Analysis

To ensure a systematic approach, content analysis was used as the primary tool for secondary data analysis, supported by qualitative coding techniques. Software such as NVivo was employed to code the documents based on predefined themes aligned with the study. Patterns, trends, and gaps were uncovered through this analysis, which informed the overall program and complemented the findings from primary data collection. Additionally, the results from this secondary data analysis helped refine the research objectives and guided areas for stakeholder interviews and focus group discussions. This ensured that the primary data collection would build on the existing knowledge base.

Qualitative Data Analysis

The data analysis for this study employed a comprehensive, qualitative approach designed to capture rich insights into the IFC programme (2019–2024) and its impact on maternal and newborn health. The qualitative data, collected through interviews, focus groups, and observations, were accurately transcribed to support the development of a preliminary coding scheme based on the research questions and key themes of the study. These codes were systematically applied to the data, allowing the team to categorize and organize the findings into clear thematic areas. Thematic categories were aligned with the primary focus of the study, such as community engagement, programme effectiveness, barriers to MNH, and sustainability of interventions. Each theme was carefully defined and substantiated with direct quotes from participants, providing a robust and transparent link between the data and the themes identified.

To deepen the analysis, the team explored the relationships between these themes to understand their interactions and how they influenced programme outcomes. This allowed for the identification of patterns and insights that were crucial for understanding the programme's successes and challenges. Special attention was given to ambiguous or contradictory cases, ensuring that these complexities were carefully examined to provide a balanced and thorough perspective.

The analysis also emphasized **lessons learned** and **future interventions**. By examining the interplay of themes, the study was able to draw conclusions about what worked well in the programme and what areas require further attention. This approach not only facilitated the identification of effective strategies but also highlighted areas that need improvement for future interventions aimed at enhancing maternal and newborn health. In summary, the data analysis process was designed to provide a holistic and nuanced understanding of the programme's impact, ensuring that the findings contribute valuable insights for future MNH initiatives and policies.

2.3 Ethical Considerations

We adopted the following ethical considerations for the assessment:

- ✓ The evaluation strictly adhered to the "Ethical Guidelines for Conducting Research Studies Involving Human Subjects" prescribed by Bangladesh Medical Research Council (BMRC).
- ✓ Before each interview (regardless of method or respondent), the objective of the study, the purpose, potential benefits of the study and potential risks of the respondents were explained clearly by the study team members. Then the team member asked for verbal consent from the respondent in the study. The administration of tools was only continued after the respondent (s) provided consent. The respondents were informed that they could disrupt or even discontinue the interview any time they wanted.
- ✓ The data collection was conducted in a way that did not disturb the service provision at the facility or disrupts the service providers.

3.Lesson Learnt of IFC Programme and Best Practices

The *Working with Individuals, Families, and Communities (IFC) to Improve Maternal and Newborn Health Programme (2019–2024)* implemented innovative, community-centered strategies to strengthen health systems and empower vulnerable populations. Over five years, the programme tested scalable approaches from courtyard sessions and citizen-led accountability mechanisms to grassroots mobilization and digital training yielding critical insights for future interventions. This chapter synthesizes key lessons and best practices derived from the IFC experience, organized around core themes: demand creation, health worker capacity building, community feedback systems, and local governance engagement. Each section highlights actionable takeaways, demonstrating how participatory, rights-based approaches can transform maternal and newborn health outcomes. By documenting these learnings, the chapter aims to inform policymakers, implementers, and stakeholders seeking to replicate or adapt successful models in similar contexts.

3.1 Demand Creation through Courtyard Sessions and CHW Household Visits

Background & Context: *In the project areas, communities initially had limited awareness of maternal and neonatal health services. Government community health workers (Health Assistants, Family Welfare Assistants) were few or absent, leaving a gap in outreach. BRAC's Shasthya Kormis (SKs) stepped in to fill this void, working as a "last-mile" link to educate families and encourage service uptake. Many women were not using antenatal care or facility delivery due to low awareness and cultural reservations. For example, at first some women felt uncomfortable attending mixed-gender meetings, limiting their participation in community forums. This context underscored the need for proactive demand-generation activities at the household and community level.*

Implementation Highlights:

The IFC programme leveraged courtyard meetings (yard gatherings in villages) and door-to-door household visits as key demand creation strategies. Trained SKs and female volunteers conducted regular home visits to counsel women and families on topics like antenatal care (ANC), postnatal care (PNC), nutrition, immunization, family planning, and the benefits of giving birth in facilities. In the afternoons, SKs organized courtyard sessions where groups of women (and often their husbands or mothers-in-law) came together to learn and discuss health issues in an informal setting. These sessions were participatory – SKs used visual aids, storytelling, and Q&A to engage attendees. Crucially, the project also involved local community groups in these activities: members of Community Groups (CG) and Community Support Groups (CSG) and the newly formed Community Action Groups helped mobilize neighbors to attend the courtyard sessions and reinforced the messages in their neighborhoods. Over time, as trust grew, even men began attending or supporting these forums, which helped address the initial gender barrier (at first women were shy to sit with men, but this concern faded as communities saw the value of the discussions).

Key Results:

Courtyard meetings and household counseling proved highly effective in raising awareness and changing health-seeking behavior. Stakeholders consistently cited the courtyard sessions as one of the most impactful interventions for stimulating demand for maternal and newborn health services. Through these forums,

community members gained knowledge on critical issues – e.g. recognizing pregnancy danger signs, the importance of at least four ANC visits, and the availability of free services at community clinics. As a result, previously reluctant families started utilizing care. A government health worker observed that before,

> *"People were not much aware…those health workers [from government] are no longer there. But now community people are aware through the activities of the BRAC–IFC project. They join the meetings…Previously they didn't like to take services. But now they take these services from their nearby facilities.".*

Indeed, facility data and testimonies indicated increased uptake of services at community clinics (CCs) and Union Health & Family Welfare Centers -a "considerable" rise in ANC visits, facility deliveries, and childhood immunizations was noted in project villages. The door-to-door visits were especially important for reaching pregnant women who could not attend group sessions; these personalized counseling visits-built trust and often led to referral of high-risk cases to facilities. By engaging husbands and mother-in-laws in conversations, the project also began shifting social norms – husbands became more supportive of their wives' care, and elders more accepting of facility-based services. In summary, demand-generation activities created a more informed community, ready to seek care for mothers and newborns, which in turn was reflected in higher service utilization at local health centers.

Challenges Encountered:

A significant challenge was sustaining these activities with limited resources. Courtyard sessions involve logistical costs (materials, tea and snacks for participants). Mid-project, the sessions had to be paused for around six months due to funding constraints, even though both community and officials found them valuable. This interruption showed how resource-dependent these forums were. Cultural barriers also needed delicate handling – in conservative areas, it took time to convince families to allow women to attend meetings (some initial sessions saw poor attendance due to purdah norms or skepticism). The COVID-19 pandemic disrupted community gatherings in 2020–21, forcing a temporary shift back to mostly household visits for outreach. Additionally, the government's lack of community health staff meant BRAC's workers had to cover large populations, stretching their capacity. Despite these hurdles, the project mitigated issues by adapting strategies – when group sessions stopped, SKs doubled down on household visits to continue messaging. They also gained support from local leaders (e.g. Union Parishad members and religious leaders) to endorse the meetings, which gradually overcame community resistance.

Lessons Learned:

Courtyard meetings and door-to-door visits are powerful, low-cost tools for behavior change in rural communities. The project learned that regular, face-to-face engagement at the community's doorstep builds credibility and motivates people to seek care. Many community members who had never been reached by formal health services were brought into the fold through these interactions. One key lesson is the importance of consistent support and minor incentives to sustain community-based efforts. For instance, providing a small budget for tea and refreshments significantly improved attendance and the regularity of CG/CSG meetings attached to the courtyard sessions – an approach that the government could adopt to keep such groups active. Another lesson is the need to address gender and cultural barriers proactively: by involving male family members in separate forums (tea-stall talks, mosque announcements) and having female health workers lead women's sessions, the project gradually normalized discussions of maternal

health in a traditionally reserved society. Over the five-year period, communities not only gained knowledge but also confidence – women began voicing their needs and men became allies in maternal care. However, the decline in community meeting frequency after the project ended highlighted that such demand-creation activities require institutionalization. Integrating courtyard sessions into routine government outreach (e.g. via monthly community clinic forums) or securing local funding for their continuation is crucial so that the momentum is not lost. Another important lesson is the value of collaboration between SKs and CHWs. Since most of the SKs live in or come from the same community, and the government frontline health workers (such as CHWs and CHCPs) are based in the same union or upazila, they already interact with each other on a regular basis. This existing connection provides a strong foundation for building collaboration, enabling them to complement one another's roles and strengthen collective efforts. By working together, they can foster greater community trust, enhance participation in health-related activities, and ensure more inclusive outreach. In this context, the IFC project should actively leverage this opportunity to promote structured collaboration between SKs and frontline health workers, thereby creating a more coordinated approach to improving community engagement and overall health outcomes.

Figure 3.1: Lesson Learned from Courtyard Sessions and CHW Household Visits

In conclusion, the IFC project's experience shows that empowering communities with information in convenient, culturally sensitive ways can dramatically improve health service uptake, and these approaches are sustainable with modest ongoing support and community ownership.

3.2 Integrating ECD, RMC, and Health Rights into Training Manuals & Modules

Background & Context: *At the start of Phase II, training for health workers in maternal-newborn care mostly focused on clinical skills, with little coverage of psychosocial or rights-based topics. Concepts like Early Childhood Development (ECD), Respectful Maternity Care (RMC), and patients' health rights were not systematically included in government training curricula for community or facility providers. This gap meant front-line health workers were less prepared to counsel families on child stimulation or to ensure respectful, rights-based care. Given the importance of these topics for quality MNH services (ECD interventions improve child outcomes, RMC and rights awareness improve patient satisfaction and uptake), the project aimed to embed them into health worker training. BRAC and Enfants du Monde saw an opportunity to update training content and thereby influence national standards by working in close collaboration with the Ministry of Health.*

Implementation Highlights:

The IFC programme successfully integrated ECD, RMC, and health rights topics into training programs for both its own community health workers and for government health staff. On the community side, all BRAC Shasthya Kormis (SKs) in the project received dedicated training modules on ECD (early stimulation, responsive caregiving, early learning), on Respectful Maternal Care (ensuring dignity, privacy, informed consent during care), and on basic health rights and entitlements. These modules were added to the regular SK training curriculum. In 2022–2023, the project provided refresher trainings to SKs focusing specifically on ECD, rights, and RMC every two months, supplementing the routine monthly refreshers of BRAC's health program. Field managers and Program Organizers used these sessions to reinforce new content and boost SKs' confidence in delivering the messages during household visits. On the government side, the project worked with the Community Clinic Health Support Trust (CCHST) and relevant ministry units to incorporate similar content into training for health managers and providers. The online training platforms developed for Upazila-level doctors and managers included a substantial ECD component that had not been part of their prior government training. Participants noted that *"ECD was not included in [our] training module of MOHFW, which was an addition to their knowledge"*, highlighting how the project filled that gap. Moreover, the project advocated for institutional uptake of these topics: it recommended that the next national sector program incorporate ECD into the official MNCH training manuals for health workers under DGHS and DGFP. By the project's end, draft plans were in place to include early childhood development in government training curricula moving forward (though formal adoption was pending).

Key Results:

The inclusion of ECD, RMC, and rights content led to measurable improvements in health worker knowledge and practice. BRAC's 19 SKs in the project area, plus over a thousand other BRAC SKs from adjacent districts, were trained on these topics and subsequently reached tens of thousands of community members with ECD and respectful care messages. For instance, after receiving the new training, SKs in Rajshahi and Rangpur disseminated ECD knowledge to over 84,000 women and 50,000 men during their community visits and spread respectful care messages to about 50,923 pregnant mothers and 17,460 husbands. This cascade indicates that training front-line workers in these areas dramatically extends the reach of such concepts. In the government cadre, 20 facility managers/doctors took the online course that included ECD and rights; they reported that while much of the medical content was refresher for them, the ECD portion was *"Something new, relevant and effective for better child health service delivery"*. Trainees also expressed increased appreciation for RMC principles – for example, a participating doctor noted that unlike typical clinical trainings, this one emphasized public health and patient-centered care, which was valuable for their work. The incorporation of rights in SK training yielded more confident health workers: SKs felt better equipped to inform women of their entitlements (like free maternal services, the right to be treated with respect) during home visits. In community forums, they began educating people on topics like the right to quality care and how to demand accountability, which was previously not part of their repertoire. Overall, by the end of the project, a stronger culture of rights-based, respectful care had taken root among the health workforce in the project area. This is evidenced by feedback from community members – about 74–95% of women in the target sub-districts reported awareness of their right to access quality MNH services, a significant rise attributed in part to the project's training and outreach efforts. The ACP survey

highlighted the need for strengthened supervision and accountability mechanisms to address behavioral concerns among CHCPs. It also underscored the importance of refresher training for CHCPs and the reconstruction of selected facilities. Following the training and awareness activities, the discussion notes from the national workshop of the IFC project indicated that 100% of healthcare providers demonstrated respect toward clients and listened attentively to service seekers.

Challenges Encountered:

Introducing new content into established training systems came with challenges. One issue was alignment with government systems: while the project developed these modules and even trained some government staff, there was no formal government order mandating this training. The project had to arrange sessions through informal coordination with civil surgeons and health managers, which it did successfully, but it meant the content was not yet institutionalized nationally. Efforts to officially revise government training manuals to include ECD/RMC were ongoing as the evaluation noted, *"ECD was not included in [MOHFW's] training module"* previously, so incorporating it required high-level approvals that take time. Another challenge was the COVID-19 pandemic, which halted planned in-person training for government community health providers (like CHCPs). The project pivot to an app-based online training for CHCPs delayed the rollout; by 2023 the CHW online training was built but not fully implemented due to these disruptions. Moreover, being a pilot initiative, the scale was relatively small – only a subset of health workers received the new training directly under the project, so its full impact depends on scaling through government adoption. Finally, sensitizing health workers to rights and respectful care required shifting mindsets. Some experienced providers initially saw these as "soft" topics; the project had to demonstrate how they improve service quality and outcomes. Encouragingly, once trained, many became champions of the new approach, but that initial inertia was a barrier.

Lessons Learned:

The project's experience underlines that enriching health worker curricula with ECD, RMC, and rights content is both feasible and highly beneficial. Trainees found these topics immediately useful and applicable – a clear indication that such training fills an important gap. One lesson is that working within existing structures (like BRAC's regular refresher training or embedding content in government OPs) is an effective way to introduce new modules. By piggybacking on scheduled trainings and adding in ECD/rights, the project ensured these concepts were not taught in isolation but as part of routine capacity building. Another lesson is the value of advocacy and partnership with government: to make these enhancements sustainable, the project had to engage government counterparts early. The MoU with CCHST and interactions with DGHS/DGFP units were important for laying groundwork to integrate the content officially. The evaluation recommended incorporating ECD

into the national training curriculum for the next sector program, which suggests that the advocacy message was heard. Going forward, ensuring a *formal uptake* (e.g. updating the national training manuals and including RMC, ECD, rights in government trainers' guides) will be key – this is a lesson that pilot interventions must translate into policy change for long-term impact. Lastly, the project learned that health workers become more effective and change agents when armed with knowledge on rights and respectful care. Many SKs noted that after the training, they could better engage communities and answer questions on sensitive issues. This empowerment of providers is critical: when they are confident and informed, they pass that empowerment to families. Thus, investing in such training has a multiplier effect on community health outcomes. The programme's success in Phase II can inform nationwide improvements – as one scale-up idea, BRAC suggested gradually introducing SK training on rights & ECD in other districts and even using digital refreshers to spread the content more widely. In summary, integrating ECD, RMC, and health rights into health worker training was a forward-looking innovation of the project, and the lesson is that it should be continued and expanded through collaborative efforts between NGOs and government for systemic change.

3.3 Online Interactive Training for Providers and CHWs (Self-Learning & Assessment)

Background & Context: *Ensuring continuous training for healthcare providers and community health workers is challenging, especially during crises like COVID-19. Traditional in-person workshops can be costly and hard to scale to a large workforce. During the project period, the team faced the reality that many government field staff (e.g., Community Health Care Providers at clinics) needed training, but gathering them for classroom sessions was impractical under pandemic restrictions and time constraints. This led the IFC programme to pioneer an online interactive training approach, aligning with global trends of e-learning. The idea was to create a self-paced digital course that providers could take on their own devices, with quizzes and feedback to reinforce learning. At the time, online training was not widely used in Bangladesh's health sector, although some e-toolkits existed. The project aimed to demonstrate that a digital platform could efficiently reach many providers and CHWs, refresh their knowledge, and introduce new concepts (like ECD) at relatively*

Implementation Highlights:

The project developed two e-learning platforms using a vendor (COdesign) – one tailored for community-level health workers (CHCPs, FWAs, etc.) and another for health managers and facility-based providers. The content was drawn from the IFC training curriculum and included modules on maternal and newborn care, health promotion, early childhood development, and community engagement techniques. Each module consisted of multimedia lessons (readings, short videos, slides) followed by interactive self-assessment quizzes to test knowledge. Trainees could proceed at their own pace, and the platform tracked their progress. For community health workers (the CHCPs and other government front-liners), the plan was to host the training on a mobile app – this was especially important since many CHWs are stationed in remote clinics. By late 2022, the BRAC team had developed this app-based course, with technical input from Enfants du Monde,

and it was entering a testing phase. For health managers (e.g., resident medical officers, upazila medical officers), the online training was launched earlier. Login credentials were distributed individually by BRAC field staff, and about 20 managers/providers in Brahmanbaria district enrolled and completed the course. Notably, the training approach was novel: it required no face-to-face sessions, yet included features like self-assessment and (in some instances) forums for trainees to ask questions. The project did conduct satisfaction surveys after the online training to gather feedback for improvement. Throughout implementation, one limitation was lack of integration with government IT systems – the e-learning site was hosted separately by the vendor, since getting it onto a government server or DHIS2 system was not immediately feasible. However, the project documented the process, aiming to eventually advocate for migrating the platform under government ownership (for sustainability). In summary, despite pandemic and technical hurdles, the IFC project rolled out an interactive e-learning solution as a pilot for modernizing health worker training.

Key Results:

The online training proved to be an effective and well-received mode of capacity building. Among the 20 health managers and providers who completed the e-course, feedback was overwhelmingly positive – they found the content relevant and the learning experience engaging. Participants liked the self-paced format and interactive quizzes, which kept them accountable to learning outcomes. Importantly, they gained new knowledge: for instance, these providers noted that the ECD segment was entirely new to them (government trainings they attended before had been purely clinical, with no early childhood development component). Having this addition "refreshed their memories" on MNH topics and *"was something that was new, relevant and effective for better child health service delivery"* according to the trainees. The convenience of the online modality was highlighted – managers could complete modules without leaving their post, which is critical as they are often overstretched with duties. A satisfaction survey found that the course met participants' expectations and *"they learned something new"*. Though the CHW-focused app training was delayed, by project's end BRAC HNPP expressed intent to open it up to CHCPs in 2024, given the success observed with the managers' training. The project considered the online approach a cost-effective solution for broad reach: once developed, additional trainees can be added at minimal cost, making it scalable. In fact, the evaluation identified this *"online-based learning modality with self-assessment"* as a key innovation that could enhance knowledge of a large number of health workers in a budget-friendly way. Another result was indirect: the project's foray into e-learning caught the interest of the Ministry's Bureau of Health Education (BHE), which had its own e-toolkit. It became clear that synergizing these efforts (e.g., merging IFC modules into the BHE toolkit) could amplify the impact – this recognition was itself a positive outcome, creating a pathway for integration. Lastly, the success of online training during COVID demonstrated resilience – training objectives were met despite lockdowns, ensuring that capacity development did not stall even when gatherings were impossible.

Challenges Encountered:

Several challenges surfaced in implementing the online training. First, technical and integration issues: the platform was hosted on a private vendor's website, not linked to the government's systems (like DHIS2). This meant that data on who completed the training and their scores were siloed, and the opportunity to auto-update government HR records was missed. The reason was that getting official permission to use

government servers or link to DHIS2 would have taken longer than the project timeline allowed. While understandable, this posed a risk to sustainability – once project funding ended, maintaining an external platform could be costly. Second, connectivity and device access were limiting factors. Not all CHWs, especially older or rural ones, had smartphones or reliable internet. The project attempted to address this by allowing content download for offline use (leveraging approaches used by BHE's toolkit), but connectivity was still a barrier for some. Third, limited coverage: by endline, only 20 government staff and a pilot group of CHWs had benefited, which is a small fraction of those in need. The CHW module was still awaiting full deployment (so much so that the evaluation couldn't assess its effectiveness because it wasn't operational during data collection). Scaling up would require buy-in from the Ministry and perhaps donor support for a wider rollout. Fourth, lack of formal recognition: because the training was not institutionalized, participants did not receive any official certification or incentive (apart from personal gain in knowledge). In health systems, recognized certificates can motivate uptake; their absence might have deterred some potential trainees. Finally, the project team noted that coordinating such an innovation without a Government Order meant relying on personal motivation and informal agreements – for example, Civil Surgeons and UHFPOs were cooperative in nominating trainees, but the process could have been smoother under a formal directive.

Lessons Learned:

The experience yielded important lessons for future digital training initiatives. First, the project confirmed that *online self-learning platforms can effectively complement traditional training*, and even replace aspects of it, provided trainees have connectivity and devices. The enthusiastic response from health managers shows that even in low-resource settings, busy professionals appreciate flexible, tech-based learning. Second, the content must be aligned with learners' needs – the inclusion of interactive quizzes and relevant new topics (like ECD) kept learners interested, which is a lesson in instructional design. Third, integration with existing systems is crucial for sustainability. The project learned that in hindsight, exploring ways to host the platform on a government or BRAC server and linking it to national e-learning frameworks (e.g., the DGHS eToolkit or Learning Management Systems) would have been beneficial. This points to a lesson: involve the government's MIS/IT department early when developing such innovations, so that transfer of the platform post-project is easier. Indeed, the evaluation recommended that in future the online modules be merged into BHE's toolkit or similar, to ensure continuity. Fourth, *blended approaches might enhance effectiveness*. While self-paced learning was good, some participants suggested periodic live Q&A or refresher webinars for interaction. The project's finding that CHCPs "preferred formats that allowed real-time interaction" indicates that a blend of self-learning with occasional live discussion could yield even deeper understanding. Lastly, the project underlined the importance of formal recognition and advocacy: it is a lesson that to scale up, one should advocate for the online course to be officially accredited (so that health workers get credit or points for completion). Additionally, informing higher officials of the cost-effectiveness and positive outcomes can spur policy support. In fact, by project's end, the approach was recognized as one of two key innovations of IFC Phase II "integrated into the national health system" (the evaluation considered ACP and online training as significant innovations). While MOHFW had not yet institutionalized it, the seed was planted. In conclusion, the IFC programme's venture into interactive e-learning teaches that with thoughtful design and strategic integration, digital platforms can rapidly build capacity among health workers, and future programs should build on this foundation – linking such platforms to national systems and expanding access so that more of the health workforce can be reached efficiently.

3.4 Active Citizen Participation (ACP) Surveys

Background & Context: *To reinforce accountability and service quality at the community level, the IFC programme introduced Active Citizen Participation (ACP) surveys – a form of community-led audit of health facilities. Bangladesh's health policies encourage community engagement, but before this project, mechanisms for meaningful community feedback were weak. Each community clinic (CC) had a Community Group and Support Groups on paper, but these rarely assessed clinic performance systematically. Meanwhile, formal complaint systems (like suggestion boxes or a hotline) were underutilized due to lack of awareness. The ACP intervention was conceived to fill this gap by empowering citizens to assess their local health services and advocate for solutions. It aligns with social accountability tools (e.g., community scorecards or citizen report cards) and was in line with national priorities to increase community oversight of primary healthcare. Essentially, ACP surveys provided a structured way for communities to voice concerns, measure satisfaction, and directly engage with duty-bearers (health providers and local officials) in improving services.*

Implementation Highlights:

The project formed Community Action Groups (CAGs) as the vehicle for ACP. Each CAG, comprising 15 members with a mix of existing CG/CSG members and other active community volunteers, was trained on how to conduct the ACP process. The ACP survey itself was a participatory tool: CAG members, with guidance from BRAC staff, would survey community members (especially service users like pregnant women, new mothers) about their experiences at the clinic. They gathered data on aspects such as the availability of medicines, cleanliness of the facility, staff behavior, waiting times, and any barriers faced. In addition to client feedback, the CAGs inspected facility conditions (often using a checklist) – for example, checking if the clinic had a functioning toilet, electricity, essential equipment, etc. Once the information was collected, the CAG convened an interface meeting (effectively a local workshop or public forum) where they presented the findings to the clinic's service providers, the Upazila health managers, and importantly, to Local Government representatives (Union Parishad members). Problems identified (e.g., "no running water in the clinic," "the satellite clinic is not held regularly," or "women feel disrespected by staff") were openly discussed. These meetings often led to jointly developed action plans – the stakeholders agreed on steps and who would take responsibility. For instance, if the ACP revealed a broken tube well, the Union Parishad chairman might commit to fund its repair; if staff attitude was an issue, the UHFPO might pledge to counsel or train the staff. The project organized at least two upazila-level workshops to share ACP findings more broadly and solidify action plans. Throughout, BRAC's role was facilitative: providing training, tools (questionnaires, score sheets), and follow-up support to ensure actions were tracked. By the end, a total of 73 CAGs were established (56 for CCs and 17 for larger Union facilities) and 1,095 CAG members trained, covering all project clinics. This intensive community mobilization was a hallmark of the ACP implementation.

Key Results:

The ACP surveys had a transformative impact on community-facility relations and led to concrete improvements. They effectively linked the community, local government, and health providers in a problem-solving loop. Key results include:

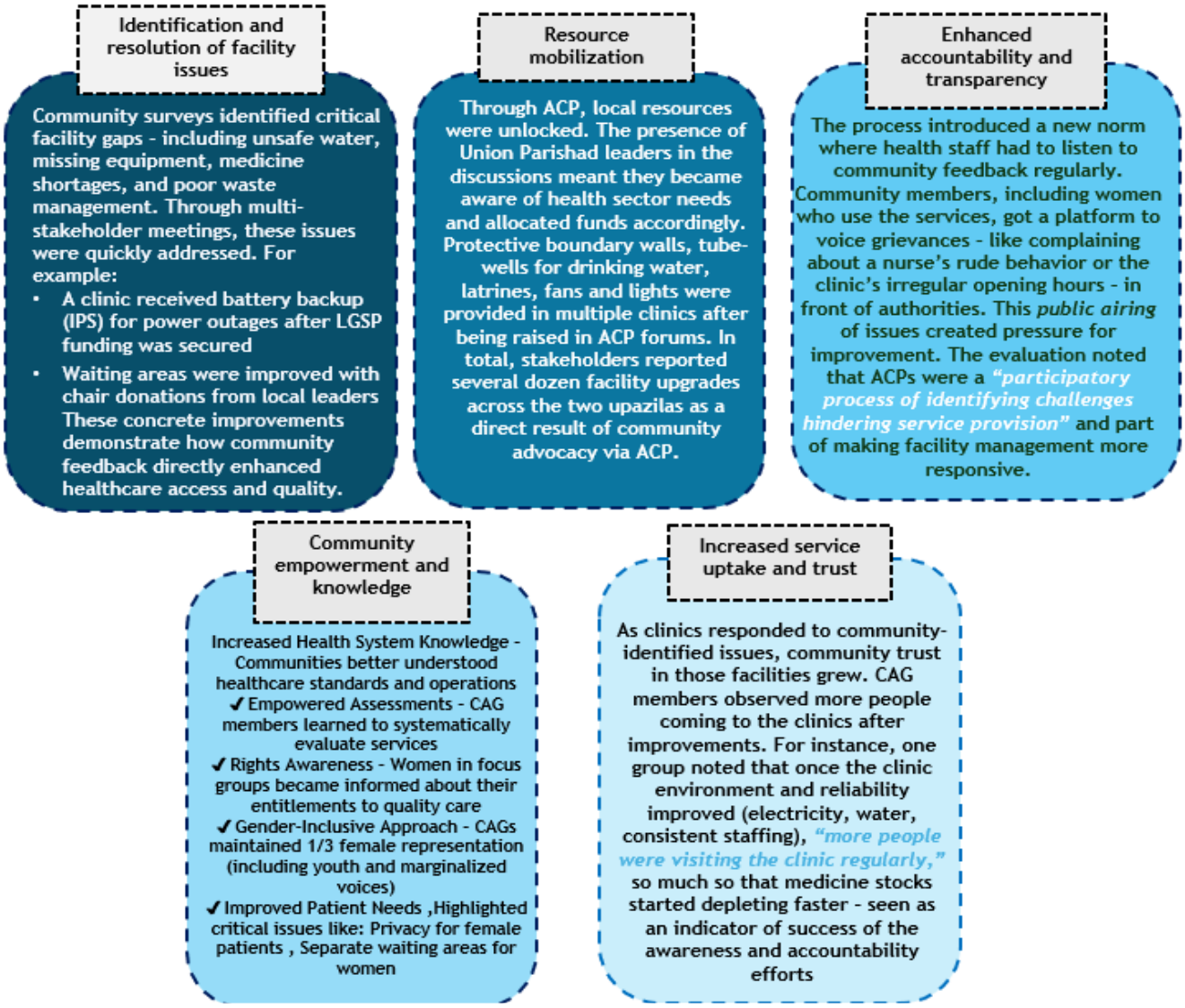


Figure 3.4: Key results of ACP Surveys

Overall, ACP fostered a collaborative atmosphere: rather than communities feeling helpless about poor services, they became proactive partners in fixing them. This result is in line with national Quality of Care frameworks, which emphasize citizen feedback; in fact, the project's ACP approach mirrored the kind of community "watch groups" envisioned by the Ministry's RMNCAH Quality Improvement strategy.

Challenges Encountered:

Implementing ACP was intensive and not without difficulties. A primary challenge was avoiding duplication and role confusion among community groups. Since CGs and CSGs already existed with overlapping mandates, introducing CAGs led to some confusion. In practice, many CAG members were drawn from the CG/CSG, and in some cases they did not clearly distinguish between these roles. Non-CAG members of the CG/CSG initially felt left out of the ACP process – some wondered if the creation of CAG meant the CG/CSG were inadequate. The project had to manage this carefully, explaining that CAG was a subset working on specific tasks, and it encouraged CG/CSG leaders to participate in ACP forums. The evaluation later pointed out that perhaps ACP responsibilities could have been assigned to the existing CGs to simplify structures. Another challenge was resource intensiveness. Conducting surveys, training volunteers, and organizing forums at each facility required significant staff time and logistics (travel, meeting expenses). This raised questions of sustainability – BRAC supported these during the project, but who would ensure ACP meetings happen regularly once the project ended? In fact, after project support was withdrawn, many CAGs became less active: members stopped meeting regularly and some issues began to languish without follow-up. This highlighted the challenge that, without institutional embedding (e.g., the government adopting ACP as a routine exercise), the momentum could fade. Additionally, there were initial apprehensions: health workers at first were defensive about being "evaluated" by the community. The project overcame this by framing ACP as a supportive process, not a witch-hunt, and involving health staff in developing the action plans. Maintaining data quality and objectivity in the surveys was another concern – volunteer surveyors had to be trained to avoid bias. Some clinics had low literacy community members, so administering surveys required translation and patience. Lastly, ensuring responsiveness – while many issues were resolved, some were beyond local control (e.g., need for an extra staff position or a new building). In such cases, the CAGs could only escalate the issues to higher authorities and hope for the best, which could be discouraging.

Lessons Learned:

The ACP initiative offers rich lessons for community engagement in health. A crucial lesson is that community-led monitoring dramatically improves problem identification and can spur solutions that outsiders or officials might miss. By formalizing a role for community members to evaluate services, the project tapped into local knowledge and energy. The approach demonstrated that *"community-led appraisals like ACP surveys can be effective tools"* for identifying and addressing local health system challenges. Another lesson is the importance of linking community action with local government support. ACP's success in resource mobilization came because Union Parishad leaders were actively involved; hence, future models should always integrate local authorities into the feedback loop. The evaluation explicitly noted that engaging LGIs was instrumental and recommended continuing such citizen–LGI–provider collaboration for oversight. On the other hand, the overlap of committees taught a lesson: *avoid fragmentation.* It may be more sustainable to strengthen one existing committee per facility with an ACP mandate, rather than creating new parallel groups. The project has informed the government that CGs/CSGs themselves could run ACP-style appraisals given the right training and incentives, which could be a more streamlined approach in the national program. Additionally, the need for institutionalization was a key lesson. Social accountability activities like ACP require continuous support – the project's end showed that they risk fizzling out otherwise. This points to making ACP part of the government's routine community clinic operations (the endline recommendation was for the Community Based Health Care programme to

facilitate regular ACP surveys and even public hearings at CCs). The project also learned to increase community representativeness – for instance, ensuring women CAG members could attend upazila workshops (some initial workshops had fewer women, leading to a recommendation to include more community women's voices). Lastly, it learned that closing the feedback loop boosts community trust. Where CAGs not only identified problems but also later communicated back what was fixed (or why something wasn't), the community's faith in engagement grew. This kind of transparency and follow-up is essential. In summary, ACP surveys taught that empowered communities can be drivers of health system improvement, but the process works best when embedded in formal structures and supported consistently. It's a model that the Ministry of Health could scale up, as it aligns with their strategy for citizen engagement and has proven effective in the Bangladesh context.

3.5 Facility Management Committees (FMCs) & Community-Based Problem Solving

Background & Context: *Many issues affecting service quality at primary health facilities (like community clinics and union health centers) stem from gaps in facility management – infrastructure maintenance, supply logistics, staffing, etc. In Bangladesh's health system, Facility Management Committees (FMCs) or similar community-inclusive committees (such as Clinic Management Committees or the CG/CSG at CC level) are intended to address these issues by involving local stakeholders. However, prior to the project, these committees were often inactive or ineffective. Community Clinics, for example, are supposed to have a CG (led by a Union Parishad member) to ensure the clinic runs smoothly, and CSGs to mobilize community support. In reality, it was acknowledged by the Community-Based Health Care (CBHC) program that "CGs and CSGs may not meet as frequently as they should, decisions may not be followed up," etc., leading to unresolved facility problems. Strengthening these facility-linked committees through community engagement was thus a priority for the IFC project. By energizing FMCs/CGs, the project aimed to create a local mechanism to identify facility needs (broken tube-well, need for a gate, a vacant post) and take action by leveraging community and local government resources*.

Implementation Highlights:

The project undertook several measures to activate and support facility management committees at different levels. At the community clinic level, as mentioned, the project's Programme Organizers worked to revitalize the existing CGs and CSGs. They did so by facilitating at least one meeting per committee per year with project support – essentially jump-starting the meeting routine. They also maintained regular communication with the committee chairpersons (usually the Union Parishad member) to encourage them to call the standard monthly meetings outside of project-facilitated ones. BRAC provided guidance on meeting agendas, often focusing discussions on identifying any problems at the clinic and brainstorming solutions. The project even provided light refreshments during these meetings as an incentive and courtesy, which proved effective in improving attendance and enthusiasm. In parallel, the formation of CAGs (described in section 4) supplemented the FMCs by bringing in additional community voices. Importantly, *the project linked these community groups with the formal FMC structure*. For union-level facilities for example, by sensitizing Union Parishad chairmen (who are patrons of all CCs in their union) about their responsibility towards the clinics, the project got them more involved in oversight and support. Finally, the project worked in coordination with upazila health management – UHFPOs were kept in the loop and were invited to attend some CG/CAG meetings. Though overburdened, some UHFPOs did join and even took initiative by requesting Union Parishads to fix certain clinic issues when they

(UH&FWCs), there were facility committees that included upazila managers and Union Parishad chairmen. The project helped form CAGs for these facilities too and facilitated annual joint meetings where community representatives from CAG, the facility's management committee, local UP members, and Upazila health officials all sat together to discuss issues and solutions. By doing so, it created a bridge between community-identified issues and the formal management decision-makers. Another implementation highlight was training and orienting committee members on how to mobilize resources. BRAC staff advised FMCs/CGs on tapping the Union Parishad's resources (like the 10% of UP block grants earmarked for health), and on soliciting contributions from local elites. In a few cases, they facilitated opening bank accounts for community clinics so that any donated funds could be managed transparently (this was suggested in operational memos as a step to channel community/leader contributions). The presence of local government officials in committees was leveraged

learned of them. In summary, the implementation combined reactivating community committees, fostering LGI involvement, and creating a forum (via ACP/CAG) to resolve facility-level problems through collective effort.

Key Results:

The involvement of community members and LGIs in facility management led to tangible improvements in facility conditions and service continuity. One of the most significant results was the resumption of regular meetings of CGs/CSGs in many project clinics, after a long period of dormancy. By project end, these groups were meeting more frequently than before (even if not every month, significantly more than "never"), due in part to the project's continued nudging and the small support like refreshments. This regularity meant that issues were being raised and recorded. For instance, a CG member from one clinic noted, *"We sit in monthly meetings and discuss our problems and ways to resolve them."* – a clear indication of a functional committee. With active committees, many local problems got addressed promptly. Notably, committees, with Union Parishad help, tackled infrastructure deficits: installing or repairing tube-wells and toilets in clinics that had none (improving water and sanitation for patients); contributing ceiling fans, lights, or furniture to make the environment more patient-friendly; and even minor renovations like fixing flooring or painting walls in dilapidated facilities. The Union Parishad chair of one union utilized the UP budget to build a protective boundary around a clinic after the FMC raised concerns about cows wandering into the premises. Another key outcome was enhanced supply monitoring: CG members began taking initiative in overseeing medicine supplies. In some clinics, community members would check the medicine stock against the allotment list every few months, and if they found shortages, they would bring it up with the Upazila managers. This kind of community monitoring helped reduce petty stock leakages and ensured the clinic voiced its needs upward for resupply. Additionally, some committees established a small fund from local donations (e.g., collecting a token fee of 5 Taka from patients, as mentioned in one CAG discussion) to cover minor facility expenses like buying cleaning materials or light bulbs. The result was cleaner, better-maintained clinics. Another result was stronger ownership and accountability: Union Parishad leaders, after engaging with these committees, increasingly saw the clinics as part of their responsibilities. For example, multiple UP chairmen personally ensured that issues raised were solved – one UHFPO recounted a scenario: *"No bathroom and tube-well were in that facility. BRAC arranged a meeting, I was there. When I heard the problem, I requested the UP Chairman and then he solved the problems."*. Such stories illustrate a new problem-solving dynamic that took hold. Furthermore, community satisfaction and trust in facilities improved. When people saw their local clinic getting upgrades and quick fixes (often facilitated by their

own neighbors in the FMC), they grew more confident in using it. Clinics that used to be bypassed began seeing more footfall – which the project considered a success of community-based problem resolution. Lastly, the project's FMC strengthening approach contributed to sustainability: by the final year, BRAC was able to step back somewhat, as many committees were functioning with only light-touch support. BRAC's 2024 report noted that these successes *"underscore the potential impact of government initiatives aimed at regularizing CG and CSG meetings"* – suggesting that what was achieved could be maintained if the government provides a bit of support or policy emphasis.

Challenges Encountered:

Revitalizing facility committees was not without challenges. Initially, committee inactivity and apathy were deep-seated. Many CGs/CSGs had not met in years, and members were unclear of their roles. It took repeated efforts and relationship-building by field staff to motivate committee leaders to convene. Some members expected honorariums or felt, without a budget, meetings were pointless. The project addressed this by providing meeting refreshments (tea, biscuits) and repeatedly explaining the non-monetary importance of their volunteer role. Another challenge was overlapping structures and communication. With CAGs formed, there was potential tension or confusion about who should address what (as discussed earlier). The project had to carefully delineate that CAGs feed into FMCs, not replace them. In practice, this overlap sometimes meant the same individuals were meeting in multiple forums to discuss similar issues, which could cause fatigue. Moreover, time constraints on key actors posed a challenge: CHCPs (clinic providers) are the member-secretaries of CGs by government design, but they often struggled to organize meetings due to their workload and being alone at the clinic during service hours. The project helped by having BRAC POs facilitate and essentially perform the secretariat role (sending reminders, drafting minutes). Upazila managers (UHFPOs) are supposed to supervise these committees but in reality had little time – indeed the evaluation found their involvement in committee activities "not significant" beyond receiving updates. Thus, lack of full engagement by some health officials was a constraint. Variation in LGI interest was another challenge: while some Union Parishad leaders were very proactive, others were less engaged, focusing on other local priorities. The project tried to standardize support by sensitizing all Union Chairmen in the area, but results varied. Finally, a continuing challenge is institutionalizing these practices. The project could spark action during its term, but sustaining regular FMC meetings and community problem-solving requires ongoing support. Political turnover can also reset progress – a new Union Parishad might not prioritize health unless orientation and advocacy continue. By project end, there was recognition that without external stimulation, some committees might slip back to inactivity (a concern partially validated when field visits in 2025 noted a drop in meeting frequency post-project). This pointed to the need for systematic embedding of these processes into the health system's own routines.

Lessons Learned:

The efforts to engage community and LGIs in facility management provided several lessons. *Firstly, reactivating local health committees yields quick wins for facility improvement*. The project learned that relatively small inputs (like organizing meetings, providing a little meeting expense) can unlock community volunteerism and local funding that far exceeds the cost. The case of committees resolving long-standing issues (water, minor repairs) with local resources highlighted that communities often have the willingness and ability to help their clinics when given a platform. *Secondly, government buy-in is essential to sustain committee functionality.* One lesson is that while an NGO can jump-start the process, ultimately the relevant

government authority must reinforce it. For example, if the Ministry of Health issued instructions and provided a small budget for CG/CSG meetings (for refreshments, etc.), it would institutionalize what BRAC did temporarily. The project's experience showed that community groups became active when they felt supported – thus formalizing that support is key going forward. In the 5th sector program, CBHC could adopt the practice of regular CG/CSG meetings with some regulated funding, which the evaluation suggested as well. *Third, engaging in Local Government Institutes is a game changer.* The lesson that "local government representatives can generate alternative resources for healthcare services if effectively engaged" was clearly demonstrated. Facility committees that had strong LGI involvement were far more successful. This underscores that health facilities should not operate in isolation from local governance; rather, formal mechanisms to involve LGIs (like making Union Chairman the head of an FMC, which is already policy for CCs) should be activated everywhere. *Fourth, community monitoring complements official supervision.* CG members checking medicine stocks or clinic cleanliness provided an extra layer of oversight that caught issues early. The project learned that training community members in simple monitoring tasks (using checklists, maintaining a complaints register) can enhance transparency. As one outcome, some CGs started ensuring the clinic displayed citizen charters and service schedules, because they knew about these from the project. Such practices can be low-cost interventions for quality improvement. Lastly, avoid committee proliferation and clarify roles. The overlap of CG/CSG/CAG taught that while multiple groups can exist, their functions should be clearly defined to members. In hindsight, the project might have merged CAG functions into CGs for simplicity. The lesson is to strengthen what exists – e.g., by adding youth or women members to an existing FMC – rather than always forming new bodies, unless necessary. The government appears to have taken note: the recommendation for the future was to regularize existing committees and just ensure active citizen engagement within them, instead of creating separate CAGs. In conclusion, the IFC project's community-centric approach to facility management showed that when community and local officials jointly take responsibility for health facilities, many local problems become solvable. It's a lesson in decentralization and community empowerment that the health system can build nationwide.

3.6 Interactive & Participatory Education Sessions on Health Rights and Empowerment

Background & Context: *A core objective of the IFC approach was to empower individuals, families, and communities with knowledge about their health rights and to promote equitable, respectful care. In rural Brahmanbaria, the concept of "health rights" – such as the right to quality maternal healthcare or the right to be treated with respect and dignity – was not well understood by the general population. Women, in particular, often did not realize they were entitled to certain standards of care. Baseline findings showed that while communities had some awareness of basic health practices, understanding of patient rights and the confidence to claim those rights were low. Furthermore, social norms (e.g. women deferring all decisions to husbands or accepting mistreatment as "normal") hindered them from demanding better services. To address this, the project implemented interactive, participatory education sessions focused on health rights, gender empowerment in health, and community health responsibilities. The approach was in line with the WHO's IFC framework emphasis on "increased ability to stay healthy" and "demand for quality care" through community engagement. It also responded to Bangladesh's national strategy calling for community awareness of rights and accountability in healthcare.*

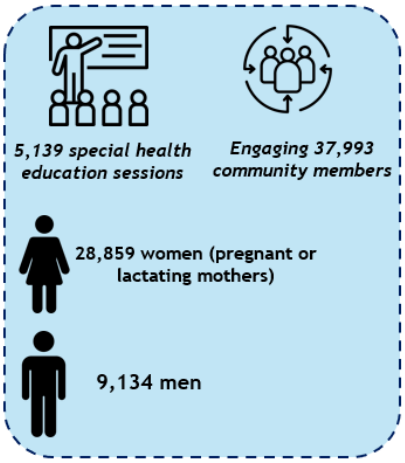
Implementation Highlights:

The project organized a variety of community education forums that used participatory methods to discuss topics of health rights and empowerment, often integrated with maternal and newborn health education. Key formats included: Mothers' forums at Community Clinics – these were group sessions for pregnant women (and sometimes their female family members) held at the clinic or nearby, led by the BRAC Program Organizers or skilled health workers. For example, POs arranged special health education sessions for women in their 1st and 2nd trimesters when they came for services. During these sessions, facilitators emphasized recognizing maternal danger signs, the importance of timely ANC/PNC, and introduced the idea that *women have the right to these services and to be treated well*. They encouraged questions and shared stories, making it interactive. For women in later pregnancy (3rd trimester), SKs held courtyard meetings in the community, ensuring even those who couldn't travel to the clinic could participate. In these, aside from health practices, SKs talked about birth planning as a right (e.g. every woman deserves a safe delivery with a skilled attendant). The sessions often used visual aids like flipcharts depicting respectful vs. disrespectful care, to spark discussion.

To involve men and other community stakeholders, the project innovated with male dialogue forums – notably, informal gatherings at tea stalls and village meeting spots in the afternoons. At these, POs or male staff would engage men (husbands, fathers, community leaders) in conversations about maternal and newborn health needs, highlighting the role of men in supporting women's health and the notion that *"healthy mothers and children are a family's right and asset."* These forums were highly participatory; men were encouraged to share their views or misconceptions, and facilitators respectfully corrected myths and provided key information (like why facility delivery is safer, or why women should be treated kindly by health providers). In some sessions, case studies were used – e.g., a story of a husband who lost his wife due to not allowing her to go to the hospital, to illustrate the importance of changing behavior. The project also sought out existing community platforms for spreading empowerment messages: local religious leaders (imams) were sensitized to mention health rights in mosque sermons, and schoolteachers were given talking points to discuss issues like early marriage and pregnancy risks in adolescent clubs. The emphasis was always on participation – rather than lecturing, facilitators used question prompts ("What do you think a pregnant woman should expect when she goes for a check-up?") to generate discussion that would lead into rights topics (such as *"she has the right to privacy during an exam"*).

A critical element was integrating the topic of Respectful Maternity Care (RMC) into these sessions, as part of health rights. Women were informed that things like obtaining consent, not being abused verbally, having a companion during labor – are all part of their rights. To make it relatable, sessions often had women share experiences: some described being shouted at by nurses, which opened a discussion on how that is not acceptable and how to address it. The project prepared simple rights literacy materials – e.g., a leaflet listing "Your Health Rights" in Bangla, which was distributed during forums (these included the right to information, right to access care, right to respectful treatment, etc.). In total, the project used these interactive education sessions as a cornerstone to build a more empowered community that can interact with the health system on an equal footing.

Key Results:



The participatory education approach led to greater awareness and attitude shifts in the community regarding health rights and gender roles in healthcare. Over the course of the project, a large number of people were directly reached through these forums: in the two upazilas alone 5,139 special health education sessions were held, engaging 37,993 community members

This wide coverage significantly increased knowledge. Surveys and endline assessments indicated that awareness of specific health rights improved. For instance, by project end, 74%–95% of women in the project upazilas were aware of their *"right to access quality MNH services"*, a figure notably higher than before. Discussions with community members revealed concrete changes: Women started voicing their needs more during ANC visits – e.g., asking health providers questions (something many didn't do before, out of fear or deference). Husbands demonstrated greater involvement – one indicator was that the proportion of husbands accompanying wives to health visits rose anecdotally, as reported by SKs, because men now understood it as part of their responsibility. In male focus groups, men acknowledged learning that "pregnancy is not just a woman's issue, it's a family issue," reflecting a more supportive stance that the forums cultivated.

Crucially, women felt *more empowered to demand respectful treatment*. After these sessions, some women reported that if a health worker treated them harshly, they knew they could complain or at least they recognized it was not their fault. While not all would formally complain, this mindset change is significant. In fact, health workers themselves noticed a change: one CHCP noted that women were now coming earlier for ANC and "asking for services they never asked for before," such as blood pressure checks or counselling on newborn care – indicating they knew what they should receive. Another outcome was the breaking of certain cultural barriers. Previously, in some villages, it was taboo for women (especially young pregnant women) to speak in public or for men to discuss childbirth. The regular forums normalized these conversations. As Mr. Kamrul (a CHCP) observed, religious and cultural norms initially kept pregnant women away from clinics, *"however, due to the dedicated work of female volunteers conducting yard meetings and vaccination drives, community awareness has increased. Women now understand the importance of antenatal visits and many complete at least four visits during pregnancy."*. This demonstrates a positive behavior change resulting from repeated sensitization. Another result was enhanced community solidarity – women in the forums formed support networks, encouraging each other to seek care and sometimes going to facilities in groups. In adolescent clubs, the youth who were engaged became messengers to their families on issues like delaying marriage and ensuring maternal care, which is a longer-term impact on empowerment. Overall, the sessions seeded a culture of informed demand: communities started to not only utilize services more (e.g., facility deliveries increased in the project areas year over year) but also to expect certain standards. This is a foundational shift towards accountability, as empowered patients are more likely to push for quality.

Challenges Encountered:

Changing deep-rooted norms and educating communities about rights is inherently challenging. One issue was initial resistance or indifference – some community members were skeptical, thinking "rights" is an abstract concept or not relevant to them. It took time for the facilitators to translate rights into everyday context (e.g. "You have the right to ask the midwife to wash her hands – that's about your safety"). Another challenge was sensitivities around gender and power. Talking about women's rights in a patriarchal setting had to be done tactfully. Early on, a few male community leaders questioned why such topics were being discussed, worrying it might make women "too assertive." The project managed this by involving those leaders in the process (inviting them to sessions, addressing their concerns, and showing that empowered women's health benefits the whole family). Additionally, low literacy levels meant that written materials had limited reach; hence sessions relied more on oral and visual communication. There was also the challenge of time and scheduling – getting people (especially busy mothers or working men) to attend sessions regularly was tough. The project overcame some of this by tagging onto existing gatherings (e.g., after mosque prayers for men, or on clinic days for women) and by keeping sessions concise and engaging. Another challenge was ensuring that the knowledge gained translated into action – empowerment is an incremental process, and while awareness rose, not every woman immediately started demanding her rights. For example, some women, despite knowing respectful care is their right, still felt shy to speak up to a doctor. Overcoming that requires ongoing confidence-building, which one-off sessions can't fully achieve. The project partly addressed this by repetition and by fostering peer support (women encouraging women).

Finally, it was challenging to measure the impact on empowerment quantitatively. The project had indicators for awareness, but empowerment (the ability to make decisions, to speak up) is harder to quantify. The impact evaluation gave mixed signals – interestingly, a draft of the BRAC JPGSPH impact survey suggested a *reduction* in some knowledge/awareness indicators among men and women, which contradicted the qualitative observations of the end evaluation team, who saw increased awareness and facility use. This discrepancy might be due to methodological issues or pandemic-related backslide. It highlighted the challenge that empowerment outcomes need careful, context-sensitive measurement. Regardless, the qualitative evidence strongly indicated positive change, even if surveys didn't fully capture it.

Lessons Learned:

One key lesson is that health rights and empowerment education must be ongoing and interactive to be effective. The project found that lecture-style messaging wouldn't have worked – instead, open discussions, where community members could share experiences and clarify doubts, were crucial. People learn and internalize concepts like rights better when they actively participate (e.g., role-playing a clinic visit scenario). Thus, future programs should invest in training facilitators in participatory techniques and allocate sufficient time for community dialogue, rather than just one-way IEC campaigns. Another lesson is the importance of engaging men and community leaders in what might traditionally be seen as "women's issues." By bringing men into the conversation at tea stalls and via mosque engagements, the project helped create a more supportive environment for women to exercise their rights. Men started to see themselves as stakeholders in maternal and newborn health, which is a big shift. The implication is that male inclusion strategies (husbands' forums, champion fathers, etc.) should be standard in maternal health programs aiming for women's empowerment.

The project also learned that leveraging existing social structures enhances reach and legitimacy. Working with Adolescent Clubs added credibility, as these are government-supported platforms, and using market committees or imams lent local legitimacy to the messages. This taught that partnership with other ministries or sectors (like Ministry of Women and Children's Affairs for youth clubs, or religious affairs for mosque involvement) can strengthen community health education initiatives.

Moreover, the project realized that awareness of rights is the first step to accountability – once communities know what they deserve, they are more likely to seek it. The lesson here is to pair rights education with avenues to act on those rights. In IFC, that pairing was with the ACP surveys and feedback mechanisms. Women who learned about respectful care in an empowerment session could later voice a complaint in an ACP meeting if they were mistreated. This coordination amplified impact and is a best practice: rights education should go hand-in-hand with establishing feedback channels or community groups so that knowledge leads to collective action.

The project's focus on danger signs and health practices alongside rights proved wise, because communities could see the practical value. Rights were taught not in abstraction but through immediate health needs (e.g., "you have the right to skilled care because it can save your life if X danger sign occurs"). This pragmatic framing is important in rights education, making it relevant and urgent. The take-away is that empowerment sessions should integrate rights with tangible health information and solutions, ensuring communities see it as part and parcel of improving health, not a separate academic concept.

3.7 Grassroots Platforms for Community Mobilization (Markets, Mosques, Tea Stalls, Adolescent

Background & Context: *Recognizing that communities are not monolithic and that different segments congregate in different venues, the IFC project strategically aimed to extend its reach beyond conventional health settings by leveraging grassroots societal platforms. In rural Bangladesh, local markets, mosques, tea stalls, and youth clubs are influential gathering points where information and ideas spread organically. Prior to the project, health promotion efforts often missed adult men, community leaders, and adolescents – groups who are critical in decision-making and norm-setting but who rarely attend clinic-based meetings or women-focused forums. For instance, men would chat at tea stalls or after prayers at the mosque, but maternal health or family health rarely featured in those conversations. Similarly, adolescent boys and girls had their own clubs (like the Kishore–Kishori clubs under MoWCA), but these were not being tapped for maternal-newborn health education. The project thus identified these grassroots platforms as key opportunities to mobilize broader community support for maternal and newborn health, reaching people in the spaces where they naturally gather and feel comfortable.*

Implementation Highlights:

The project team integrated outreach into the fabric of community life by collaborating with local institutions and informal networks. Some notable implementation strategies:

Market Committee Engagement:

In each union, BRAC staff approached the chair of the local bazar (market) committee – these committees manage the affairs of periodic rural markets where large crowds, including men from surrounding villages, convene. The project arranged to have short health advocacy sessions or announcement times on market days. For example, market loudspeakers (often used for public announcements) were utilized to broadcast messages about upcoming health camps or encourage husbands to support their wives' clinic visits. In some cases, a health stall was set up on market day, where men could come get their blood pressure checked or receive an informational leaflet, which served as a conversation starter about family health. The presence of community group members and local elites at these market sessions lent credibility; over time, market committees themselves became advocates, reminding shopkeepers and patrons about health program messages (such as distributing handbills on safe delivery practices).

Mosque Involvement:

The project recognized the mosque as a powerful venue for community messaging given the high attendance of men at weekly Jummah prayers. Through coordination with local religious leaders and the Islamic Foundation, the project supported brief health talks during mosque gatherings. Imams were sensitized (via orientation meetings) on maternal and newborn health imperatives and were provided with suggested khutba (sermon) points that align with Islamic principles – such as the importance of the mother's health in Islam, or the duty of a husband to ensure care for his pregnant wife. Many imams responded positively, delivering messages like ***"saving the life of a mother and baby is a blessed act"*** and encouraging vaccination and medical care, which helped counteract any misperceptions that modern healthcare might conflict with religious beliefs. Additionally, mosque courtyards were used for occasional community meetings, leveraging the trust people place in the mosque environment. By explicitly including mosques, the project sent a strong signal that maternal and child health is a community (not just women's) concern and one that aligns with local values.

Tea-Stall Meetings:

The ubiquitous rural tea stall (a roadside small café) is where men gather leisurely, especially in afternoons and evenings. The project's male staff (and sometimes supportive local men from the CAGs) frequented these spots to spark informal discussions. They might, for instance, start a conversation with a group of men about a recent incident (e.g., a difficult childbirth or a maternal death in another area) to draw interest, then share guidance on birth preparedness or newborn care, making sure to solicit the men's opinions and questions. These tea-stall chats were purposefully kept very informal – the staff did not lecture but rather steered the conversation, injected accurate information, and dispelled myths. Often, one success would be identifying an influential man (say, a respected shopkeeper or schoolteacher) at the tea stall and getting him on board with the messaging so he could champion it among peers. The project even organized a few structured "tea stall forums" where they invited men for a

Adolescent Clubs (Kishore–Kishori Clubs):

These government-run clubs for teenagers provided an avenue to shape health attitudes early. The project collaborated with the Ministry of Women and Children Affairs' local offices to integrate maternal-newborn health and rights topics into club activities. BRAC organizers and occasionally healthcare providers (FWVs or nurses) conduct sessions at these clubs using games, quizzes, and storytelling appropriate for youth. Topics ranged from adolescent nutrition and delaying early marriage/pregnancy to how teenagers can help their mothers during pregnancy or be advocates for health in their community. The project found that adolescents, once informed, were enthusiastic messengers – some club members took the initiative to perform little skits in their villages about safe motherhood or to assist in organizing courtyard meetings for women. By engaging in these clubs, the project tapped into a network of young volunteers who infused energy and creativity into

special extended discussion at a tea stall on specific afternoons – serving tea and snacks to create a friendly atmosphere while a health facilitator guided the talk. **Through 1,016 such tea stall forums, they reached over 9,100 male participants with vital health information in a comfortable social setting.**	community outreach. This approach is also aimed at long-term change: today's informed adolescents would be tomorrow's informed parents. While working with youth, the project ensured to involve parents and community gatekeepers to avoid any backlash – explaining that these were life skills and health education efforts complementary to their regular activities.

Key Results:

Utilizing grassroots platforms significantly broadened the reach and inclusivity of community mobilization. Several notable results emerged:

- **Male Engagement and Support Grew:** Traditionally, maternal health programs struggle to involve men, but through markets, mosques, and tea stalls, the project engaged thousands of men on these issues. Consequently, men's awareness and positive attitudes increased. Anecdotally, community health workers reported that more husbands began accompanying their wives to the clinic or ensuring funds were saved for emergencies, reflecting a shift in the household decision-making dynamic. In community surveys, the proportion of men who knew at least three danger signs of pregnancy or newborn illness rose compared to baseline, which can be attributed to these outreach efforts (exact figures were captured qualitatively, as referenced by improved male knowledge in endline discussions). Additionally, men started voicing support in public forums – for example, in a community meeting, a Union Parishad member (who had heard messages at the mosque and tea stall) stood up to urge other men to allow and encourage women to go for facility deliveries, indicating a normative shift.
- **Increased Community Dialogue in Social Spaces:** Health topics became part of everyday conversation. One can measure this by the fact that people began bringing up maternal-newborn health in various community forums unprompted. The tea stall conversations often continued even without project staff present – men would discuss among themselves what they heard, sometimes debating things like the pros and cons of facility vs home birth. Such integration into social discourse is a big step towards sustainable behavior change. Market committee members also occasionally took initiative – for instance, some markets put up posters (provided by the project) about the government maternity allowance or about danger signs, and merchants would remind customers to seek care, demonstrating ownership of the messaging.
- **Youth as Change Agents:** Through adolescent clubs, about 200–300 youths (rough estimate across clubs in two upazilas) received training/input on MNH and rights. These youths in turn disseminated information to siblings, friends, and neighbors. A concrete example was observed in one village where the Kishori Club members organized a courtyard meeting for mothers and themselves explained the importance of colostrum feeding and immunization, which they had learned – a clear replication of knowledge. Teachers reported improved knowledge among students on these health topics, and some early marriages were reportedly averted or delayed due in part to awareness raised by club discussions on the health risks (club members convinced a couple of families to postpone weddings until girls were 18+ citing health reasons, something noted in project anecdotes).

- **Cultural Acceptance of Health Messaging Improved:** By embedding messages in respected local contexts (religious and community gatherings), the project lent them a stamp of social approval. When an imam spoke about maternal health being important, families took it as endorsed by faith, breaking any perception that modern health practices conflict with tradition. This led to greater acceptance of interventions like birth planning or vaccinating newborns, even among conservative segments. In effect, working through these platforms reduced resistance and helped align healthy behaviors with community values.
- **Resource Mobilization and Sustainability Potential:** Another indirect result was that local institutions started contributing resources. For instance, one market committee decided to allocate a small portion of their committee funds to build a shed next to the community clinic so that market-goers could get health information on market days under shade – they saw value in continuing some form of health outreach at the market even beyond the project. Similarly, some mosques began institutionalizing health messages (the local Islamic Foundation office considered developing a standard khutba on health rights, inspired by the project's pilot). These steps indicate potential for sustainability: community-led structures incorporating health promotion into their routine.
- **Broader Community Mobilization:** Overall, by engaging various grassroots platforms, the project mobilized a wider cross-section of the community than would have been reached otherwise – including elders (through mosques), business people, fathers and grandfathers (markets, tea stalls), and youth (clubs). This comprehensive approach fosters a supportive environment around women and newborns; it's not just the mothers who are targeted, but everyone around them. As a result, when a pregnant woman needed to go to the facility, her family and community were more likely to support and assist her, having been sensitized through one channel or another.

Challenges Encountered:

Working with informal and diverse community platforms also brought challenges. Coordination and consistency were one – these platforms were not under project control, so scheduling and ensuring regular messaging required diplomacy and persistence. For example, markets are busy and chaotic; sometimes planned announcements got cut short due to other events or local politics. Similarly, reliance on imams meant the content and emphasis could vary; not every imam would deliver the messages exactly as briefed, and some might avoid sensitive topics. The project mitigated this by careful selection of willing clergy and providing written sermon guides, but a few mosques were less cooperative (perhaps the imam was not comfortable or too traditional).

Engaging men in tea stalls, while fruitful, occasionally faced pushback – a few men questioned why outsiders (NGO staff) were preaching to them at leisure spots, or there might be one or two influential individuals dismissing the message in the beginning. Field staff had to have good social skills to navigate these situations, sometimes taking a step back and approaching someone the group trusts. Timing was another challenge: aligning with prayer times, market days, club meeting schedules etc., required flexibility, and staff often worked evenings or weekends to meet people where they were.

With adolescent clubs, there was sensitivity in discussing reproductive health in a culturally appropriate way. The project had to carefully tailor the content to not offend parents – focusing on health and life skills rather than topics that could be seen as too explicit and ensuring separate discussions for boys and girls

when needed. There was at least one instance where a parent was concerned about what was being taught; the project team had to explain the curriculum and assuage fears.

Lastly, measuring the direct impact of these diffuse activities posed a challenge. Changes like increased male support or normative shift are hard to quantify. The project relied on qualitative feedback and indirect indicators (like increased facility use or anecdotes of behavior change) to infer success, which while convincing, could benefit from more formal documentation.

Lessons Learned:

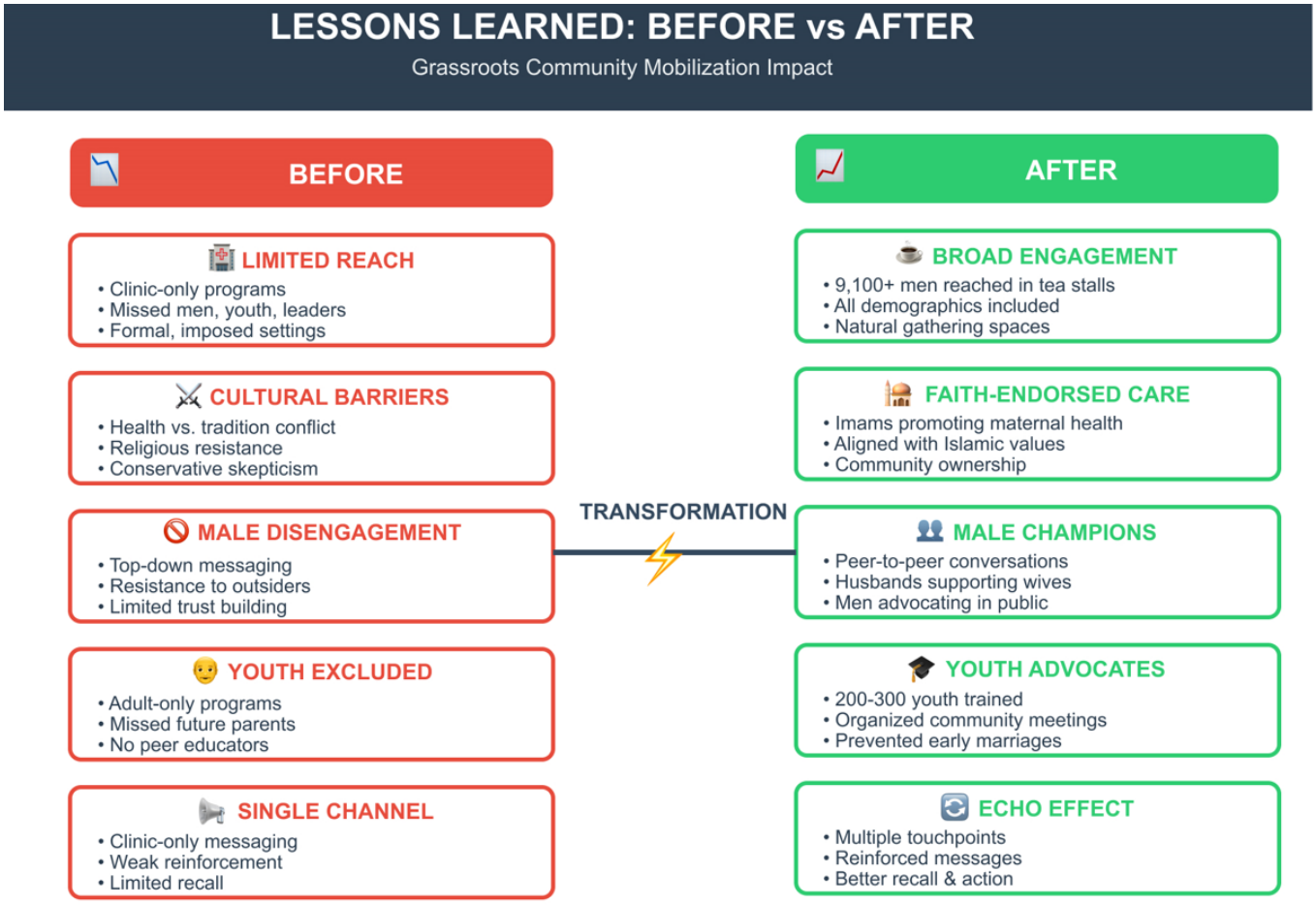


Figure 3.7: Lesson learned from Grassroot Community Mobilization Impact

The use of grassroots societal platforms yielded several lessons for future community health initiatives. ***First, meet communities where they naturally gather.*** The project affirmed that health programs should step out of clinics and typical meeting halls and into the everyday venues of community life. By doing so, they can engage demographics that are otherwise missed (men, youth, leaders) and do it in a way that feels organic rather than imposed. This approach can dramatically enhance reach and acceptance of health messages, as people are more receptive in familiar social settings.

Second, cultural and religious alignment is powerful. Partnering with mosques and framing health in the context of local culture and faith removed potential cultural barriers and gave the messages moral weight. The lesson is that working with religious and cultural institutions is not just respectful but strategic – it roots health behaviors in the community's own value system, which is key for sustainability. Future programs should engage such local influencers from the start and equip them with knowledge so they can be long-term advocates.

Third, the project learned the importance of informality and respect in engaging male audiences. The tea-stall strategy showed that men respond better to peer-like conversation than formal lectures. The facilitators who succeeded treated the men as equals, listened to their perspectives, and then guided them to correct information. This respectful, dialogue-based approach-built trust. The lesson is that when engaging men (or any group), one should leverage existing social dynamics and avoid a top-down tone. Also, involving men in solving problems (like asking "what would you do if your wife had a complication at night?") made them more invested in the solutions, rather than just telling them what to do.

Fourth, youth can be effective change agents when empowered with knowledge. The enthusiasm of adolescent club members indicated that given the right information and a bit of guidance, young people are eager to contribute. They often came up with creative ways to spread messages (dramas, songs, social media posts in some cases), amplifying the impact. Engaging youth also secures the future – today's informed adolescents become tomorrow's informed parents. The lesson is to systematically include adolescent and school-based interventions in community health programs, working in tandem with education and youth departments.

Finally, a lesson is that diversifying communication channels reinforces messages. By hearing about maternal health from multiple sources – an imam at Friday prayer, a peer at the tea shop, a health worker at the clinic, a poster in the market – community members were more likely to remember and act. Each platform reinforced the other, creating an echo effect. This multi-pronged approach is more effective than relying on one channel. It acknowledges that behavior change is a social process, not just an individual one, and saturates the social environment with consistent messaging.

3.8 Strengthening Community Feedback Mechanisms (Complaint Boxes, Hotlines, Public Hearings)

Background & Context: *An accountable health system requires channels for users to voice feedback and grievances, and for authorities to respond to them. In Bangladesh, formal community feedback mechanisms do exist – for example, suggestion/complaint boxes at facilities and a national health hotline (16263) – but these were not widely known or effectively used at the local level. Community members often assumed nothing would come of a complaint, or they feared repercussions. There was also little culture of proactive grievance redress at facility level; many suggestion boxes stayed locked and unchecked. Recognizing this, the IFC programme aimed to strengthen community feedback mechanisms as part of building a responsive MNH care environment. This meant both improving the use of existing tools (like complaint boxes and hotlines) and introducing more direct, participatory feedback forums (analogous to public hearings) where community concerns could be aired and addressed. Enhancing these mechanisms was aligned with national directives on citizen's charters and grievance redress in public services, which call for more responsive systems. It was also complementary to the project's ACP and community group efforts, providing another layer for community voices to be heard.*

Implementation Highlights:

The project took a multi-faceted approach:

- **Complaint Box Reactivation:** BRAC staff surveyed the target facilities to see if they had complaint boxes and how they were managed. In places where no box existed or the old one was defunct, the project helped set up new suggestion boxes (often simple padlocked boxes placed in a visible spot in the clinic). More importantly, they worked with facility staff and CGs to institute a routine: opening the box regularly (e.g., weekly or biweekly), reviewing any notes, and discussing them in staff or community meetings. They also made the suggestion box more accessible – for instance, placing paper and pencil nearby, and sometimes anonymously writing a sample feedback and reading it out (to demonstrate the process). The presence of community group members in this process was encouraged, to build trust that complaints would be seen by more than just the health provider. Clinics were also encouraged to display the hotline number (16263) on their noticeboards, and BRAC staff and CHWs actively informed people about it during health forums, explaining what kind of issues one could report there.

- **Awareness and Encouragement Campaign:** The project realized that having mechanisms is futile if people don't know or feel safe to use them. Thus, an awareness drive was included in courtyard sessions, mothers' forums, and even tea stall talks, focusing on patients' rights to give feedback. Facilitators conveyed messages such as: *"If you face any problem at the clinic – say the provider isn't there or mistreats you – you **can** speak up. You can drop a note in the box or call this number. It is your right to demand good service."* They demystified the idea of complaining by reframing it as constructive feedback and part of improving services. To overcome fear, they assured confidentiality (e.g., "you don't have to put your name if you don't want") and gave examples of issues that were solved after community raised them (often drawing from the ACP successes). The hotline was particularly emphasized for serious grievances or suggestions that couldn't be solved locally – staff explained that 16263 is a direct line to ministry where one can report, say, a facility constantly being closed, and that it has helped fix issues elsewhere. Printed leaflets on how to lodge complaints were distributed.

- **Local Public Hearings / Community Meetings with Authorities:** While not labeled as "public hearings" formally, the project facilitated events that mimicked that function. Two notable events were the ACP findings sharing workshops – essentially, gatherings where community members (through CAGs) presented their evaluation of clinic services to upazila health managers and local government officials. These acted like public hearings: community voices were amplified, problems were acknowledged in an open forum, and officials publicly committed to solutions. Additionally, some clinics held community meetings where anyone from the community could come and speak about the clinic's services in the presence of the clinic staff and a BRAC facilitator or CG president. These were less formal than a typical public hearing but served a similar purpose on a smaller scale. For example, a clinic might organize such a quarterly meeting, inviting ward members, local elders, and service users to give feedback face-to-face. The project helped initiate these by suggesting the idea to CGs and providing moderation to keep the meeting constructive (ensuring it did not become a blame game but

focused on solutions). The presence of Union Parishad members or UHFPOs in some of these meetings provided weight; community members saw that their words reached those in power.

- **Follow-up and Resolution:** Merely collecting feedback wasn't enough; the project also focused on closing the loop. BRAC POs often took on the role of following up on complaints – for instance, if a suggestion box yielded multiple notes about medicine stockouts, they would raise it with the Upazila pharmacist or flag it in a coordination meeting. They also encouraged clinic staff to respond to complaints. Some clinics started a practice of addressing common issues on a board (e.g., "*We have received your complaints about privacy during examinations – we have now installed a screen in the consultation room"*). BRAC also monitored the hotline usage indirectly by asking community members if they had tried calling and what response they got, then feeding back any systemic issues to higher-ups. Through the CCHST liaison, they informed district/national level about patterns of complaints (like infrastructure issues beyond local capacity). Essentially, the project tried to ensure that feedback led to action, which is crucial for people to continue using the mechanisms.

Key Results:

The initiative to strengthen feedback mechanisms produced several outcomes:

- **Greater Utilization of Feedback Channels:** By the end of the project, suggestion/complaint boxes in project clinics were actually being used and checked, a notable improvement from baseline when they were mostly decorative. Community members started dropping written feedback. The content of these notes ranged from simple thanks to criticisms like "the CC needs to open on time" or "often medicine X is out of stock." This itself was a success indicator – it meant people felt empowered enough to voice issues. The project reported that over 80% of targeted facilities were regularly reviewing community feedback by 2023, whereas virtually none did so before. As for the hotline, while exact usage numbers were hard to gather, anecdotal evidence showed a handful of community members tried it after hearing about it. For instance, one community member called 16263 to report that the family welfare visitor was absent on the day of immunization; he later told the CG that a week after his call, the issue was resolved (likely meaning the message got relayed to district officials). This is a small win, but significant in demonstrating the system can work. The increased awareness of the hotline and GRS (Grievance Redress System) is a steppingstone for more usage in future.
- **Local Problem Resolution and Service Improvements:** Many issues identified through community feedback were addressed, improving service delivery. For example, in one clinic several women had anonymously complained (via the box) that the male CHCP made them uncomfortable during antenatal check-ups. Upon review, the CG and health supervisor arranged for a neighboring female health assistant to attend on clinic days to assist – an adjustment that came directly from patient feedback. In another case, suggestions about clinic environment (people wrote that the clinic compound was dirty and had no sitting area) led the CG to organize a community cleaning drive and to procure a bench for the waiting area. Moreover, when issues were raised in the public forums, they got immediate responses: if a complaint was about staff behavior, the UHFPO would speak to the staff; if about infrastructure, the UP chairman would pledge funds (some examples overlapping with ACP actions). One particularly important improvement was that after hearing repeated complaints about lack of privacy (women uncomfortable that men linger around the CC during consultations), several CGs arranged to have a partition or curtain added in the clinic and instituted a norm that male attendees wait

outside the building. This kind of change created a more women-friendly service environment and came purely from community voices.

- **Increased Trust and Willingness to Engage:** As community members saw that their feedback led to visible changes, their trust in the health facilities and authorities grew. They began to believe that "speaking up" could yield results, which is a significant cultural shift. During endline interviews, one community member said: "We put our problems in front of them (health staff/UP) and they listened. Now we know we can say if something is wrong." This indicates reduced apathy and more proactive citizenry. Health providers, on the other hand, started viewing community feedback as helpful rather than threatening. A CHCP commented that initially they feared complaints would be personal attacks, but eventually realized they helped pinpoint gaps, and with community support many issues could be fixed. This improved provider-community relationship – staff felt the community was working with them, not just criticizing.
- **Model for Local Accountability:** The combination of suggestion boxes, hotline awareness, and quasi-public hearings effectively created a local Grievance Redress System tailored to the community. The project essentially modeled how a community feedback loop can operate at primary care level. This did not go unnoticed: the evaluation noted that "being a community-based approach involving both LGIs and communities, the ACP (and related feedback forums) seemed a more effective approach to addressing grievances locally" compared to the passive existing systems. The lesson likely informed recommendations to integrate such community-led feedback in the national program. Already, it was reported that CBHC was interested in possibly institutionalizing community appraisals and even public hearings as part of their strategy.
- **Identification of Systemic Issues:** Through these feedback channels, some bigger, systemic issues were highlighted that went beyond one facility – for example, many communities complained about stock-outs of certain essential drugs (like oxytocin or newborn vaccines at times). When compiled, these pointed to supply chain issues at higher levels. The project escalated these findings to the district or through EdM to the national level, feeding into policy dialogue on strengthening drug supply. Similarly, widespread feedback about staff vacancies (several communities complained their CC had no CHCP, or the FWV rarely came) helped quantify the human resource gap and gave leverage to advocate for filling posts. In essence, community feedback not only solved local problems but also provided data for higher-level improvements.

Challenges Encounter

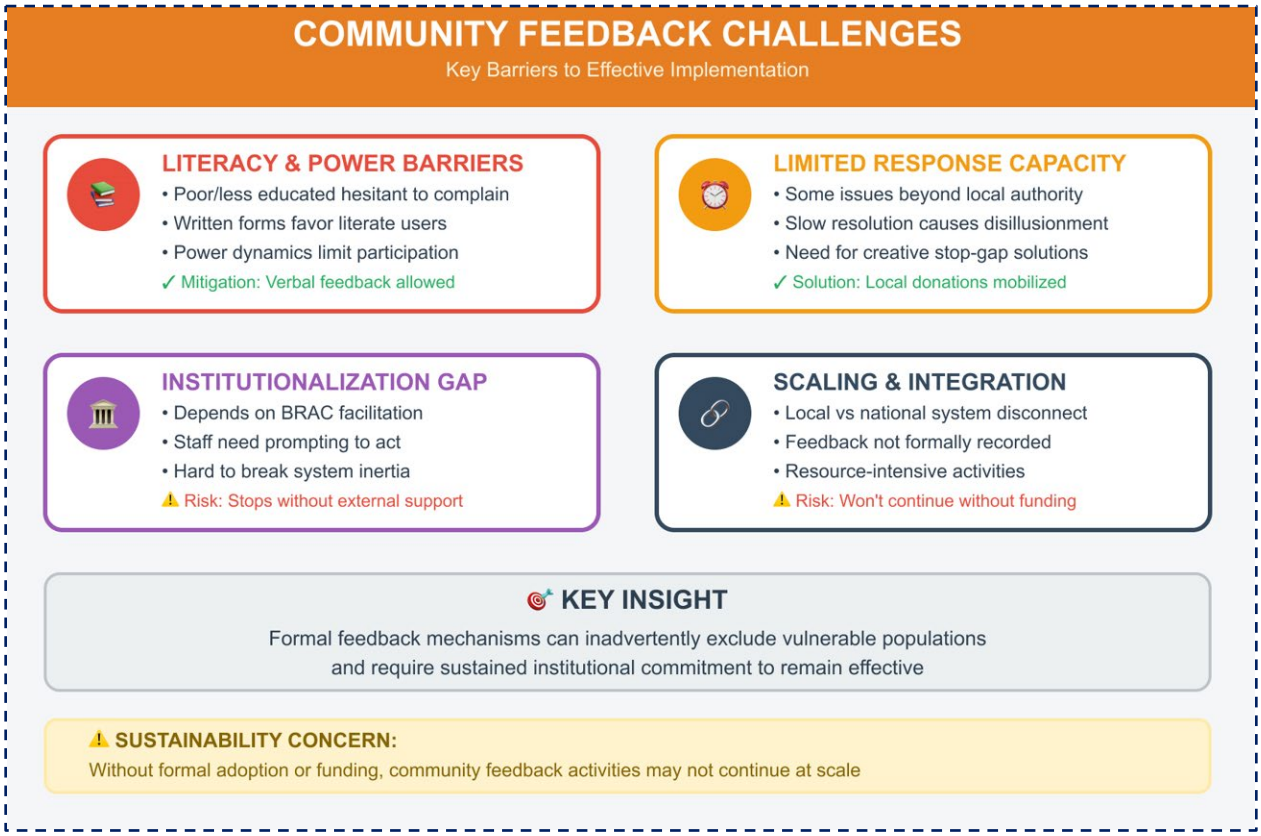


Figure 3.8: Community Feedback Challenges

Lessons Learned:

- ***Empowering communities to give feedback works, but requires building awareness and trust.*** People won't use complaint mechanisms just because they exist; they need to know about them and believe that their voice matters. The project's heavy emphasis on sensitization was essential. Future programs should allocate effort to community education on rights and feedback channels as a precursor to expecting any use of such mechanisms.
- ***Responsive action is crucial to sustaining engagement.*** One complaint addressed can do more to encourage feedback than a hundred requests to complain. The project learned to rapidly act on what was within their means – even small fixes – to show the community that the loop is working. This builds a virtuous cycle: feedback -> action -> more feedback. Conversely, unattended complaints can quickly break confidence.
- ***Combining formal and informal channels yields the best results.*** The IFC project's informal "public hearing" style meetings gave a level of satisfaction that dropping a note in a box might not. The personal interaction and immediate response in those forums were invaluable. The lesson is that a mix of written/remote mechanisms (like boxes, hotlines) and in-person, dialogic mechanisms

(community meetings, hearings) serves a diverse community's preferences and adds redundancy. What one misses, the other captures. For institutionalization, formal systems should possibly incorporate periodic community meetings as part of the grievance process.

- ***Local government and community groups can act as accountability intermediaries.*** The project found that involving UP members and CG/CAG representatives in the feedback review process improved credibility and follow-up. This suggests that these local actors should be part of the official grievance redress framework for primary health – e.g., a Union Parishad health standing committee could regularly review clinic complaints. The presence of such intermediaries addresses the power imbalance between a lone patient and the health system, and encourages mutual respect.
- ***Cultural shift among providers is needed to embrace feedback.*** Initially, some providers were defensive. Through the project, many realized community feedback is not about blame but improvement. Training or orientation for health workers on constructive handling of complaints could be good practice to derive from this. When providers see feedback as a tool for their own performance improvement, they'll be more open to it. In line with this, the national QI framework's principle of responsiveness to Citizen's Charter feedback could be reinforced in training and supervision of health staff.
- ***Resource allocation for grievance redress:*** A practical lesson is that handling grievances, especially through community forums, takes time and sometimes money (for meetings, etc.). The project's experience suggests that the health system should allocate resources (staff time, budget for community interface) to effectively run feedback mechanisms. It can't be an afterthought. The evaluation recommended incorporating such interventions into OP budgets if they are to continue.

3.9 Community Participation & Resource Mobilization via Local Government Institutes (LGIs)

Background & Context: Local Government Institutes (LGIs) *– primarily Union Parishads (union councils) and Upazila Parishads – are crucial stakeholders for community development in Bangladesh. They have administrative authority and budgets that can be used for local needs, including health. The IFC project recognized that engaging LGIs could greatly enhance community health interventions, both by mobilizing additional resources and by fostering local ownership and accountability. Traditionally, health programs have been somewhat siloed under the Ministry of Health, but the government's community clinic model explicitly involves LGIs (Union Parishad chairpersons are patrons of clinics, members are chairs of CGs). However, in practice, many LGIs were not actively participating in health facility management or promotion before this project. By 2019, with decentralization efforts and the Local Government Support Project (LGSP) in place, each Union Parishad had some discretionary funds (including a dedicated 10% for health/education) that could be tapped for health improvements. The project saw an opportunity to galvanize community participation through these elected bodies – because when the local government gets involved in a community initiative, it tends to rally the community as well. Moreover, LGIs bring sustainability prospects: unlike time-bound projects, LGIs are permanent actors that could continue supporting health activities if they see the value.*

Implementation Highlights:

The IFC programme's engagement with LGIs was woven into nearly every intervention, but there were specific efforts to channel community participation and resources through LGIs:

Sensitization and Capacity Building of LGI Members: Early in the project, meetings and workshops were held with Union Parishad chairpersons, members, and Upazila chairpersons to orient them about the IFC project's goals and the importance of maternal-newborn health in their constituencies. They were presented with local health data (like maternal mortality rates, service utilization stats) to create a sense of urgency and ownership. BRAC and EdM staff highlighted how community clinics and health workers could achieve more with LGI support. Importantly, they clarified the roles LGIs could play – for example, using union budgets for clinic repairs, advocating for staff placement, or mobilizing the community. Some training was provided on technical aspects: e.g., explaining what the MNH indicators are, or how to plan a small health project. They were also given examples of successful LGI involvement from other areas to inspire action.

Involvement in Community Groups and CAGs: The project ensured that Union Parishad representatives (who were formally heads/patrons of CGs) were actively involved in community health committees. Programme Organizers regularly communicated with UP members about upcoming CG meetings, ACP surveys, or courtyard sessions, inviting them to join. Many did attend these meetings, which not only increased their understanding of grassroots health issues but also signaled to the community that local leadership cares about health. In CAGs, beyond the CG/CSG members, some active community citizens who were not elected were included, but they often worked alongside UP members. CAG responsibilities explicitly included liaising with LGIs for resolving issues, which the project facilitated by basically bringing LGIs to the table whenever community needs were discussed. This close integration meant that when community action plans were made (post-ACP), they typically had a section "what will the Union Parishad do," to which the UP representatives would commit.

Resource Mobilization Through LGIs: A standout implementation aspect was helping LGIs use their funds or influence to support MNH. The project provided technical input to Union Parishads on small infrastructure works or procurement needed for health facilities. For example, if a clinic needed a shallow tube-well, the project might help the UP get a cost estimate and plan it in their budget or through LGSP funds. In some cases, BRAC even co-financed minor works with the UP (though generally the aim was the UP covers it). They also encouraged UPs to include health in their annual plans and ward shava meetings (local public budget meetings), effectively mainstreaming health in local development agendas. At the Upazila level, the project linked with the Upazila Health Complex management committee and the Upazila Parishad. The Upazila chairman was engaged during coordination meetings, particularly to address issues beyond the unions' scope (like assigning staff or procuring larger equipment). One tactical move: project staff and community representatives attended Upazila Parishad meetings and raised health facility needs there, often with prior briefing to the Upazila chairman so he could endorse it. This resulted in some budget allocations from the Upazila Parishad's own funds or advocacy by Upazila chair to higher authorities.

Joint Community-LGI Initiatives: The project stimulated some joint initiatives, such as local fundraising for health facility improvements. For instance, after an ACP, a Union Parishad member convened local businessmen and community leaders to pool funds for buying an autoclave for the Union Health Center, with the project's local staff assisting in organizing it. The project also got LGIs involved in non-monetary ways: Union Parishads passed local resolutions in support of things like no home delivery (encouraging families to go to facilities), and they used their social influence (like instructing mosque leaders or village police) to disseminate health messages. Essentially, health became part of the local government's agenda, not just the health department's – a key shift.

Key Result

The active participation of LGIs led to significant resource infusion and sustained community engagement in health:

- **Mobilization of Financial & In-Kind Resources:** Throughout 2019–2024, Union Parishads in the project area contributed funds to at least 72 facility improvement activities (as recorded by the project's monitoring). These included construction of clinic latrines, tube-wells, boundary walls, minor renovations (roof repairs, painting), purchasing furniture (benches, almari for medicines), installing solar panels or IPS, etc. For example, Kasba's union councils collectively installed or fixed tube-wells in 5 clinics, ensuring safe water. In Sarail, multiple unions invested part of their LGSP grant to provide electricity backups and fans to their clinics after learning through ACP that heat and power outages were hindering services. The total value of LGI contributions, as per project estimates, ran into several lakhs of taka (tens of thousands of USD). Beyond direct funding, LGIs leveraged other sources: one UP chairman lobbied the Upazila Nirbahi Officer to get a portion of a social safety net fund allocated to build a delivery room at a clinic, and succeeded. Community contributions also increased under LGI leadership – as mentioned, UP members often championed local fund drives (leading to donations of land for clinic extension in one case, or community labor for building maintenance). This demonstrated how LGIs can galvanize the wider community to contribute when they lead by example.

- **Improved Facility Readiness and Service Utilization:** Thanks to LGI-supported enhancements, many clinics became more functional and welcoming. One tangible impact: at least 3 union health sub-centers that were previously not offering delivery services (due to lack of basic amenities) became able to conduct normal deliveries after LGIs helped equip them with necessary items (like water supply, a privacy screen, or a backup power for autoclave). As a result, by 2023 those centers recorded their first set of institutional deliveries, offering women an option closer to home – a direct result of local resource mobilization. Overall service utilization at CCs also climbed. Data indicated an uptick in patient visits corresponding with facility improvements; communities responded to the nicer facilities by coming more. For instance, one clinic's monthly patient load rose from ~200 to ~350 after it got a facelift and water/toilet fixed, largely funded by the UP – a metric cited in the evaluation to show how demand met supply readiness.

- **Increased Accountability and Community Oversight:** LGI involvement inherently brought an accountability layer. Union chairmen and members, being elected and answerable to the people, paid attention to clinic performance once they were involved. Community members, in turn, felt more comfortable approaching their UP member about health issues than perhaps a medical officer.

Thus, a pattern emerged: if a clinic faced a problem (like staff absenteeism), the community could complain to the UP member who would then press the health department – a feedback loop that previously didn't exist strongly. In fact, the evaluation noted *"LGIs were found to be involved in the process, which opened a new avenue for resource mobilisation and enhanced monitoring from them".* One UP member started a routine of visiting the clinic monthly to check everything, something he was not doing before. Another result was that health staff became more attentive, knowing the UP chairman had an eye on the clinic; it wasn't just their boss at Upazila, but also local government checking in.

- **Empowered Community Groups through LGI Support:** Community groups (CGs, CAGs) gained clout and confidence when backed by LGIs. They found that when they took an issue to a UP chairman, it often got resolved, validating their role. For example, a CAG identified that a clinic had no waste pit for sharps; the UP Chairman quickly sanctioned building one. These quick wins made community volunteers more motivated. It also ensured continuity: many CG/CAG activities like meetings and follow-ups were sustained because the UP members kept them going (they have a five-year term, aligning well with project duration). By project end, LGIs publicly expressed support to continue some initiatives – e.g., one Upazila Parishad planned to allocate a small budget each year for community clinic maintenance and to continue ACP-style appraisals in some form, showing local institutionalization.
- **Policy Recognition of LGI Role:** The success in Brahmanbaria fed into policy discussions. The evaluation recommended, and MOHFW officials concurred, that engaging local government was a key lesson for scale-up. The notion that *"local government representatives can generate alternative resources for healthcare if made accountable"* was highlighted as a lesson learned. This helped reinforce the strategy in the upcoming national plan to formally include LGIs in PHC facility

oversight and resource mobilization. In other words, the project provided a proof of concept that is influencing how the government designs community health governance in the 5th sector program.

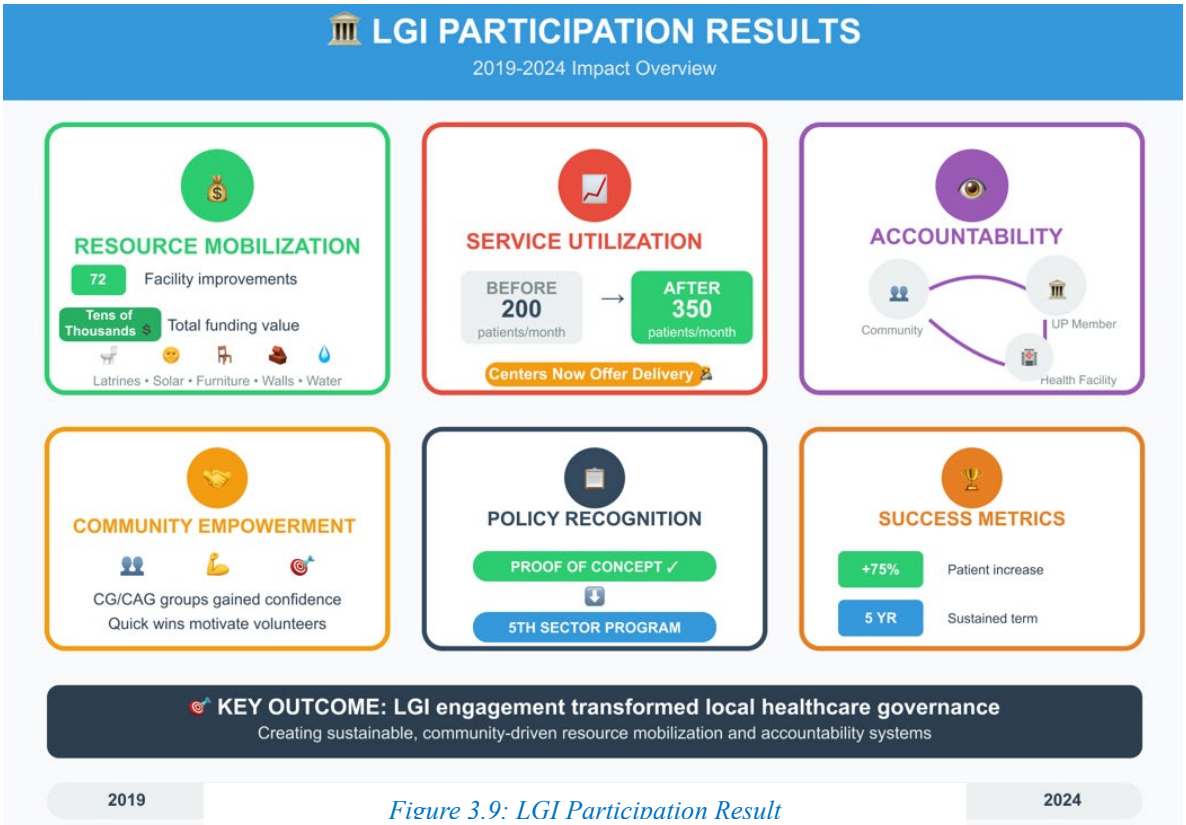


Figure 3.9: LGI Participation Result

Challenges Encountered:

Working with LGIs also had its challenges. One was varying interest and capacity among LGIs. Not all Union Parishads were equally proactive; some members were less engaged due to other priorities or political reasons. The project had to invest extra time in the less active ones or find champions within those unions (say, a particularly enthusiastic female member or a social welfare secretary) to carry the torch. Political dynamics sometimes interfered – for instance, if a Union Chairman was from an opposing party to the Upazila Chairman, coordination could suffer. The project navigated this by staying neutral and focusing on common goals, but local politics did play a role.

Another challenge was ensuring sustained commitment. LGIs have many responsibilities, and after an initial burst of support, attention could shift elsewhere (like road building, etc.). The project had to keep health on the agenda through continuous advocacy and by showing results (for example, inviting LGIs to see a clinic they helped improve now bustling with patients, to reinforce that their contribution mattered).

Budget constraints were real – Union Parishads operate on small budgets; if funds were tight or late, health expenditures might be delayed. The project sometimes faced timing issues, e.g., a planned clinic repair had to wait till the UP got the next tranche of LGSP funds. Additionally, complex issues like filling staff

vacancies were beyond LGI control; sometimes communities expected the UP to solve everything, which they couldn't (a UP can't hire a government nurse). Managing those expectations was necessary to maintain credibility of LGIs.

Also, some LGI-led efforts ran into bureaucratic hurdles: e.g., a UP wanting to donate equipment to a clinic had to go through health department approvals which took time. This occasionally frustrated local leaders.

Lessons Learned:

Several lessons stand out:

- **Engaging LGIs is indispensable for community health initiatives** – they unlock local ownership and resources that external actors alone cannot. The project proved that and thereby reinforced that future interventions should systematically include LGIs from day one.
- **Mutual accountability between health sector and LGIs benefits both.** The health system often sees local government as outside their chain of command, but this project showed collaboration yields tangible results. A lesson is that mechanisms should be established for regular interface: joint planning meetings, inclusion of LGI reps in health supervision visits, etc., to cement this partnership. The evaluation's policy implications explicitly suggest including LGI engagement in operational plans for PHC, which is an important takeaway.
- **Training and guiding LGIs enhances their effectiveness in health roles.** Many UP members had never been oriented on how they can support health. Once given knowledge and tools (like understanding their 10% health allocation, or how to oversee a clinic), they performed well. So, a lesson is to institutionalize capacity building for LGIs on health sector collaboration. The project's success in one district suggests that scaling this knowledge nationwide (perhaps through the Local Government Division or donor programs) could significantly improve rural health facility functioning.
- **Community participation is amplified when channeled through LGIs.** Rather than parallel community structures working alone, linking them with LGIs gave them more voice and legitimacy. The project learned that community groups should ideally be nested in or formally recognized by local government systems. For example, making CAGs a sub-committee of the Union Parishad could be a way forward (some discussion on formalizing community groups under UP committees came up as a future direction).
- **LGI resource mobilization has its limits but can spur additional support.** The funds LGIs have are modest, but their convening power is big. By showing willingness to contribute, they can persuade other actors (higher government, NGOs, community rich) to also pitch in. The project saw that dynamic – e.g., once the UP put some money, the health department was more willing to send some supplies, etc. The lesson is that a little local contribution can leverage bigger inputs, an important strategy for resource-scarce settings.
- **Sustainability through local government:** Perhaps the overarching lesson is sustainability. Interventions anchored with LGIs are more likely to continue after project end because local government remains. In Brahmanbaria, by project close, the Union Parishads had incorporated many health activities into their regular work (some even planning to continue the courtyard

sessions with their community development funds, as was hinted in final meetings). The project thus underlines that engaging existing local institutions (not creating parallel ones) is key to long-term continuity

4. Recommendations for the Future

The lessons presented in this document have been acquired from long experience of EdM in implementing interventions through the IFC programme. While the second phase of this programme came to an end during 2024, and EdM has not yet developed a new project/programme based on these experiences, the organisation needs to think on specific activities to ensure that some of these lessons are continued and mainstreamed into the health system of Bangladesh. In doing so, the lessons, as per the consultants, can be divided into two groups. In one group, there are lessons that can readily be integrated into the national health system, while in the other group, there are lessons that need to be further refining, and which can be done in collaboration with other development agencies. Naturally, there are two sets of activities recommended here for both these sets of lessons.

4.1 Recommendations for lessons which could be integrated into the national health system

The following lessons of EdM from the IFC programme can be included into this category:

- Demand creation activities through courtyard sessions and household visits by community health workers (CHWs)
- Early Childhood Development (ECD) Respectful Maternal Care (RMC), and Health Rights training included in government training manuals and modules
- Online interactive training for healthcare providers and community health workers (CHWs), using self-learning and self-assessment platforms

Being the major implementing agency of government, MOHFW is the obvious partner for this mainstreaming process. Bangladesh, however, is going through a transition phase due to the recent political turmoil in 2024. The health sector have been affected in this transition, with decisions like discontinuation of the proposed 5th HPNSP. The transition from the sector-wide approach in programming into an alternative approach has not yet been finalised. However, as per recent decisions from March, 2025, MOHFW has decided to develop a few development projects to continue the planned activities of 5th HPNSP during 2026 to 2028 period. Development Project Proforma (DPP) for some these projects are under development, which would be submitted to the Planning Commission for approval. This is an opportunity for mainstreaming the aforementioned lessons. In this regard, the following **recommendations** are furnished:

i. Disseminate the findings relevant to the lessons to the respective stakeholders of the proposed development projects, including the planning wing of HSD, the development wing of MEFWD, the agencies under these two Divisions of MOHFW (i.e. DGHS and DGFP) and the Planning Commission. The idea is that the stakeholders would be aware of the potential positive impacts of these interventions and the process of implementing those so that they can reflect these in the upcoming projects. This awareness building can be done through a series of dissemination sessions taking appropriate stakeholders, roundtable discussions and sharing of appropriate

dissemination materials. EdM and its partner BRAC can appropriately plan and implement these activities.

ii. Participate in the technical discussion and consultation sessions of DGHS and DGFP in development of the upcoming projects to ensure that the interventions are being considered in the design of those projects.

iii. Liaison with the technical working group members that are involved in development of these projects through one-to-one meetings and sharing the specific information so that they may consider including the interventions in the upcoming projects.

4.2 Recommendations for lessons to be developed through the efforts of other development agencies

While MOHFW is still uncertain about the next steps, a number of development agencies are active in the health sector of Bangladesh and are planning/implementing relevant interventions either through partnership with DGHS/DGFP of MOHFW, or as parallel development projects of their own. As indicated before, some of the lessons can further be refined through the efforts of these development agencies so that these can be mainstreamed into the health system later by MOHFW. The lessons in this group include the following:

- **Active Citizen Participation (ACP)** surveys
- **Facility Management Committees (FMCs)** involvement through community-based mechanisms to identify and resolve facility-level issues
- **Interactive and participatory education sessions on health rights and empowerment** involving various community stakeholders, as individual health rights are still new concepts for rural populations
- **Strengthening community feedback mechanisms** (complaint boxes, hotlines, public hearings) for improved service accountability and quality through wider community participation and resource mobilization via Local Government Institutes (LGIs)

The following **recommendations** have been furnished to develop and further refine these interventions with the development agencies:

i. Map-out the development agencies that have similar activities/intentions for health system improvement in Bangladesh in near future. For example, UNICEF will continue working on maternal and child health, and UNFPA will do the same in reproductive health, family planning and adolescent health in near future. World Bank and ADB have show intention of funding for interventions in these areas as well. EdM and its partner BRAC may conduct a through mapping of such development agencies to whom they may collaborate with in near future.

ii. Have one-to-one discussion sessions with the identified partners on how they can take forward these lessons in future. EdM may have to share the full knowledge material sets with the development agencies so that they can adapt the lessons into their own interventions for implementation.

iii. If budget permits, EdM may consider participating in future projects of these development agencies as technical assistance provider so that they can further refine these lessons and

implement those. In this regard, again, having one-to-one discussion sessions with the country and regional offices of the development agencies would be important. Coordination and follow up from the secretariat of EdM with the global offices of the identified development agencies will be required. This will enable the country offices to collaborate with EdM for implementation of the lessons.