Benchmarking visit report to Jamkhed Model In India & Brac and Icddr,b in Bangladesh

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by

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Mar. 9- Mar. 23, 2017

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Glossary

BRAC	Bangladesh Rural Advancement Committee
CRHP	Comprehensive Rural Health Project
EPHI	Ethiopian Public Health Institute
FMOH	Federal Ministry of Health
HEW	Health Extension Workers
ICDDR, B	International Centre for Diarrheal Disease Research in Bangladesh
IIfPHC-E	International Institute for Primary Health Care in Ethiopia
JHU	Johns Hopkins University
NGO	Non Governmental Organisation
PHC	Primary Health Care
UNFPA	United Nations Population Fund
VHW	Village Health Workers

Introduction

I. Background information about IIfPHC, in Ethiopia

On February 1, 2016, the Ethiopian Federal Ministry of Health (FMOH) launched the International Institute for Primary Health Care in Ethiopia (IIfPHC-E). This Institute has been established with the vision of revitalizing the Global movement "Health for ALL" through Primary Health Care.International Institute for Primary Health Care in Ethiopia (IIfPHC) developed a one year operation plan and it is currently under implementation. The project is funded by the Bill & Melinda Gates Foundations through its Grant Programme (Grant ID OPP 1152330). The planned activity comprised a benchmarking exercise to identify world-class examples of similar functioning organizations to learn from and increase the efficiency and effectiveness of the IIfPPHC. In addition, the benchmarking provides information on new developments in other countries in the areas of primary health care to inform healthcare policy development in Ethiopia. IIfPHC carries out the benchmarking, in conjunction with Johns Hopkins University Bloomberg School of Public Health.

2. Activities

2.1. Selection of benchmarking partners

Dr Henry Perry, technical advisor of IIfPHC and staff member of Johns Hopkins University Bloomberg School of Public Health, contacted his former colleagues and partners in Bangladish and India. He selected three organizations to serve as benchmark. The two institutes were BRAC, the biggest NGO in the world and icddrb in Bangladesh. The other institute was Jamkhed Model

in India. The three organizations were contacted and visits were scheduled between, February 28 to March 30, 2017.

2.2. Method of benchmarking

To benchmark critical areas, IIfPHC used the business excellence model that is developed by Malcolm Baldridge. The model is a set of inter-related criteria that aims to capture key aspects of any successful organization. Baldridge concluded seven criteria critical to the success of any organization (Criteria for performance excellence 2007 as cited by Stapenhurst). The criteria are: leadership; strategic planning; customer and market focus; measurement, analysis, and knowledge management; workforce; process management; and results.

Trip Itinerary (Feb.28 – Mar. 30, 2017)

Tuesday Feb.28:

Departure from Addis Ababa, Ethiopia

Wednesday Mar. 1, 2017:

Arrival in Mumbai – travels to Pune – 4 hours drive to Jamkhed and met the respective staff

Tuesday Mar.9:

Departure from Mombai, India to Dhaka, Bangladesh

Wednesday Mar 22, 2017:

- Travel from Dhaka, Bangladesh to Mombai, India

Thursday Mar.30, 2017

- Travel from Mombai , India to Addis Ababa, Ethiopia

Main Findings/Issues

PART ONE:

JAMKHED MODEL

(Mar.1-8, 2017)

Benchmarking visit report

C.R.H.P, Jamkhed, in India

by

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Feb.28- Mar. 8, 2017

Briefing about Jamkhed Model, in India

The Comprehensive Rural Health Project, Jamkhed (CRHP), has been working among the rural poor and marginalized for the past 47 years. Founded in 1970 by Drs. Raj and Mabelle Arole to bring healthcare to the poorest of the poor, CRHP has become an organization that empowers people and communities to eliminate injustices through integrated efforts in health and development. CRHP works by mobilizing and building the capacity of communities to achieve access to comprehensive development and freedom from stigma, poverty, and disease. Pioneering a comprehensive approach to community-based primary healthcare (also known as the Jamkhed Model), CRHP has been a leader in public health and development in rural communities in India and around the world.

Annually, CRHP provides services that directly impact 500,000 people in the state of Maharashtra. Since the opening of the Training Center in 1994, over 30,000 local and 3,000 international representatives from NGOs, governments and healthcare professionals have been trained in the CRHP approach. In other words professionals & students are trained-from India and globally. At the core of this comprehensive community-based approach is its embrace of equity for all, utilizing healthcare as a means to break the cycle of poverty. The work of CRHP has been recognized by the WHO and UNICEF, and has been introduced to communities around the world.

Overview activities

1. Met with Jamkhed model staff, March 1, 2017

- As I arrived in Jamkhed I met with Ms. Connie Gates, Dr. Raj Arole and CRHP, Jamkhed, India introduced who is American Representative Jamkhed International-North America (JINA), to community-based Primary Health Care, in 1972. She invited me to watch a film about the historical development of the Jamkhed model. She also gave to me a three weeks course timetable on Primary Health Care given by Jamkhed Institute.

2. Village Health Workers activities at the village level, March 2, 2017

Village Health Workers provide basic preventive healthcare and knowledge to their villages and help organize and facilitate Women's Groups and the Adolescent Girls Programs. VHWs also provide a great deal of care to pregnant women and new mothers. They educate women on nutrition during pregnancy and proper breastfeeding practices. In addition, they examine the pregnant women and monitor the progress of the fetus. VHWs are fully equipped to perform home deliveries and will also accompany women to a hospital delivery if they choose to do so or it is medically necessary.

Village Health Workers are expected to do: to mobilize their communities to achieve better sanitation, hygiene, and family planning; to act as mediators between the communities and the mobile health team and hospital; to provide basic preventive healthcare and knowledge to everyone in the village regardless of age, gender, caste, class, or ability to improve nutrition of women and children, and women's knowledge of their economic rights; to provide support and help facilitate Women's Groups, **Women's Self-Help Groups**, and the Adolescent Girls Program within the villages.

The Village Health Worker (VHW), usually illiterate and of low caste, is the key change agent for CRHP's comprehensive approach to health improvement. Selected by the communities themselves and trained by CRHP, VHWs not only act as health workers and midwives but they also mobilize their communities to achieve better sanitation, hygiene, family planning, and maternal and infant health. The VHWs are responsibly working with Mobile team workers.

Ms. Connie Gates and Ms. Shaila Deshpande went to Padali village, which is 20 kms far from Jamkhed. The purpose of the visit was to see the community health workers activities and also to hear the community reflection on the Jamkhed's health services.

Ms. Shaila Deshpande – Senior Training Manager. In the early 80's, inspired by hearing Dr. Raj Arole address a seminar on rural poverty, she came to CRHP for a visit and decided to stay. In 2000, she became CRHP's Training Coordinator. Shaila has been training individuals ranging from grassroots workers to heads of state for over twenty years.

In the afternoon I attended community health workers group presentations and discussions on how to diagnosis, signs and symptoms, prevention and control methods of diabetic patients. I had a meeting with mobile team members one of whom has been serving since 1974, four years after the Jamkhed model established in 1970.

I watched two video films in the Jamkhed library about the Jamkhed International training and success of Jamkhed witnessed by the many of national and international visitors and the project with SERP (Society for Elimination of Rural Poverty) in the whole state of Andhra Pradesh. Ms. Connie Gates gave to me a book about Jamkhed for our resource centre. In the evening I met with **Mr. Ravi Arole** and we scheduled the next two days (Friday and Saturday) activities that should be visited and observed. **Mr. Ravi Arole** is the Director of CRHP (including the Jamkhed Institute). He was born on May 11, 1967 in Cleveland during his parents', Raj and Mabelle's, Fulbright Fellowship. Ravi graduated from the University of North Carolina-Greensboro, with a B.S. in Computer Science, Religion, and Mathematics in 1993. He received an MBA from the University of Michigan, Ann Arbor in 2001. Ravi has worked as a Systems Analyst and then in Supply Chain Management for Fortune 500 companies. After 20 years

away, Ravi returned to India in 2005. Since then he was the Director of Operations, and now of CRHP (including the Jamkhed Institute).

During our visit at the Padali village, we met with one village health worker elected by the village community and the second women, who is a health worker assigned by the government. We all went to the house of the VHW, demonstrated and explained the activities she provide to the community. She also answered for our questions raised to her and also family members. One of the cases that she demonstrated to us was how to measure blood pressure, consulting pregnant ladies, screening for diabetic patients and high-risk pregnant mothers. She also jointly working with the health agent assigned by the government. Both of them they took us to the government child care center (no – it's preschool program), child feeding and growth monitoring center of the village. Here we have observed that different charts, instruments, playing materials and formulated food stuffs for children, pregnant and lactating mothers.

All or most of the original VHWs were illiterate, but proudly supporting the villagers due to their commitment. We have observed them having enough knowledge and skill beyond our expectation. It has been observed and expected to stay and serve the respective community as they have been selected and valued by the villagers and also have a family commitment to stay and work in the same village. Cognizant of this Jamkhed Institute is also proud of them for their high commitment and achievements.

3. Women's Groups

- **Women's Self-Help Groups (WSHGs)** are cohorts of twelve to twenty adult women who come together with the shared goal of developing economic potential and stability, both for themselves and for each member. Evolving from Women's Groups in the mid- 1970s, WSHGs, like Women's Groups, discuss village issues and learn about community health topics from the Village Health Worker (VHW) during monthly meetings. They are unique from Women's Groups, however, in that members of WSHGs work to develop economic competency and stability by participating in microfinance enterprises.

- Attended group presentations and discussions by 25 **community health workers** who

represent their respective villages and used to come to Jamkhed Institute for two days training every week. This time they were discussing about diabetic disease.

- The Village Health Worker (VHW), usually illiterate and of low caste, is the key change agent for CRHP's comprehensive approach to health improvement. Selected by the communities themselves and trained by CRHP, VHWs not only act as health workers and midwives but they also mobilize their communities to achieve better sanitation, hygiene, family planning, and maternal and infant health. When a village agrees to work with CRHP, the whole village comes together to choose a woman to be trained as their VHW.

- Whenever the community health workers are on the training, **the Mobile Team Members** used to attend for further follow-up and supervision of the ongoing activities at the community level.

- **The Mobile Health Team (MHT**) found its beginnings in the outreach efforts of founders, Mabelle and Raj Arole, and today serves as the bridge between the community and CRHP's on-campus medical and development staff. Historically, villagers have had neither the time nor the resources to travel all the way to the hospital in Jamkhed for care, and as a result, healthcare was brought to them. In order to build trust and confidence, the original outreach team provided curative services via weekly clinics in the villages, and as rapport was built, the original team developed into the MHT. Today the team possesses a broad array of capacities including health promotion, preventive health services, social work, development projects, and community organization.

- After attending the village health workers discussions, I also had a discussion with the mobile health members. This means of organizations is found to be very important to transfer information, technology and any social development activities and also a means of empowering women at large in the society.

4. The Mobile Health Team, March 3, 2017

- I had an independent discussion with the mobile team members. The Mobile Health Team helps train Village Health Workers and work side by side with them to provide health services to project villages. MHT members help lead and provide support for the Adolescent Boys and Girls Programs, Women's Self-Help Groups, and Farmers' Clubs. In addition, the MHT members work with trainees and researchers from all over the world to collect village data and educate others about the Jamkhed Model.

- They are expected to provide on-site support to Village Health Workers (VHWs) and help add authority to the VHW's decisions in the eyes of the villagers, to act as a part of a referral system in which they are the second line of defense, help dispel notions of caste, literacy, or gender barriers to ability or competence, to advise and mentor villagers in development activities such as Women's Self-Help Groups and Farmers' Clubs, and to link villages to our health center's Julia Hospital, the third and final level of our referral system. If a patient cannot be treated in the field, he or she has the option of coming to our hospital, which utilizes a sliding-scale payment system to accommodate for all socioeconomic situations. The MHT follows up with patients in their villages after discharge.

- **Mr. Yoseph Pandit** has been working with CRHP since 1978. Trained as a leprosy technician at Wanless Memorial Hospital, Miraj, he initially worked to eradicate leprosy and tuberculosis in CRHP Project Villages, but has since branched out to a wider range of roles. He is responsible for Mobile Health Team activities such as the selection and training of VHWs, community organization for watershed development activities, maternal and child health programs, as well as directing household surveys and analysis of data.

- The Mobile Team Members are primarily and proactively needs to show the Jamkhed Institute their voluntariness regardless of any benefits. Jamkhed has considered to provide some benefits for Mobile health team as well.

5.Trainings, March 3, 2017

5.1. Observations of VHWs training two days per week at Jamkhed Institute, March 3, 2017

When a village agrees to work with CRHP, the whole village comes together to choose a woman to be trained as their VHW. VHWs initially receive extensive training on CRHP's campus. Over half of the training time is dedicated to personal development in order to build self-esteem, confidence, and skills necessary for community organization and effective communication. The rest of the training is spent developing clinical knowledge and skills that equip the women to function as primary health care workers. The VHWs come together weekly for CRHP-based training to review skills, share stories, and update statistics.

I have observed that while 25 VHWs were on group work (a member of five people in a group), presented and also discussed about diabetic disease. It was surprising to hear their way of presentations regarding the sign and symptom, prevention, diagnosing, screening, control and dieting system of diabetic patients. They spent the night sleeping in a group for two days talking all the time about diabetics. The brainstorming's, debates, arguments role plays, dramas and raising cultural sensitive issues, challenges while diagnosing and screening, at the end possible solutions for smooth relations and better outcomes would be discussed and at the end of tiresome discussions reached to consensus reflected and closed by applaud of all participants including with the presence of mobile team and Instructor who has been coaching and guiding. Such knowledge and skill would be transfer to women's self help groups in the respective village and also practiced by the VHWs at the end its implementation would be supervised by the Mobile team members.

5.2. **Domestic trainings**

CRHP also hosts domestic (Indian) trainings. Trainees leave CRHP able to turn their newfound knowledge of community based primary healthcare into action in their own villages, towns, and cities. The Institute is providing tailored made trainings when requested by the government, non-government and private organizations.

Such type of trainings will have dual advantages: one them is good for the Institute reputation as

long as its quality is maintained and appreciated by the respected trainees. On the other hand, it is an opportunity as means of income for the institutional sustainability.

5.3. Jamkhed International Institute for Training & Research in Community Health & Development

The CRHP Jamkhed International Institute provides training in diploma course to participants with relevant, need-based and experiential learning in the principles and practice of sustainable community-based health and development (CBHD), learning from the villagers and staff who have developed and experienced this process. This course is designed especially for persons sponsored by their organization seeking further training to improve their community work, or for those who want to start an organization that incorporates the principles (equity, integration, empowerment) and practices of CBHD in a developing country, or in poor communities in developed countries.

The course curriculum is tailored to participants' needs, interests and experiences, with an emphasis on the practical application of concepts and skills learned. Sessions are conducted by CRHP staff and community members and encourage participatory and experiential learning through active involvement in sessions, demonstrations and discussions. In addition to classroom sessions, participants engage in village visits and discussions with community groups such as Farmers' Clubs, Women's Self-Help Groups, Adolescent Groups and Village Health Workers.

Participants do independent study of a topic of their special interest. They also develop a plan to apply their learning's to their own current or planned programs and have ongoing support and feedback during the design. A certificate is given upon successful completion of the course.

The trainees are expected to acquire a clear understanding of sustainable, comprehensive, community-based primary health care and development, to learn practical skills to develop effective health and development projects with communities', and to write a plan for the implementation of CBHD principles within one's own community project.

During my visit there was no a group of international trainees but there were foreigners two

volunteers, who are financially supported by their respective home institutions supporting and learning from the Jamkhed model after their post and undergraduates courses and will be staying for few months.

6. Farm field visit, March 4,2017

- We went to the Khadkat Farm on Saturday March 4, 2017. The Khadkat Farm goes back to the 1970's when the land was donated to CRHP by a former CRHP hospital patient. The farm runs several projects that assist local farmers and generate income. The vermiculture project creates high quality, organic fertilizer from cow dung and other waste on the farm. What fertilizer is not used on the farm is sold at market to provide an important source of income. CRHP is also in the process of creating a new water reservoir to aid in responding to drought, which will contain enough water (20 million liters) to irrigate crops on the farm and help fill wells, raising the water table in the process.

  It is expected to act as a demonstration farm for local farmers (Experts at Khadkat Farm are able to advise on a variety of subjects such as crop choices, financial returns, yields, agroforestry, and organic methods of farming), to provide 70 to 80 percent of food demands for the CRHP campus training center, living quarters, and preschool, which drastically reduces overall CRHP costs, to provide a source of rehabilitation and independence for women at CRHP's Mabelle Arole Rehabilitation Center for women who are survivors of domestic violence, burnings, and stigmatized diseases such as Tuberculosis and HIV/AIDs, and to host learning seminars to local, national, and international individuals on sustainable farming for an arid climate.

7. Week end break, March 5, 2017

- Visited a water fall near Jamkhed about 20km to the north

8. Julia Hospital visit, March 6, 2017

We went to Julia hospital in Jamkhed and were explained by Dr. Shobha Arole, who is co-director of CRHP. She was born on February 2, 1961 in Kolar, India. Growing up between the U.S. and India as her parents (Drs. Raj and Mabelle Arole) pursued their studies in medicine and public health, she has witnessed the birth and growth of CRHP. She graduated from the Christian Medical College, Vellore, India in 1986. Her medical training has taken her to Antwerp, Belgium for laparoscopic surgery, clinical counseling and pastoral care in Glasgow as well as cardiac echo and doppler studies in Japan. Dr. Arole is an ordained minister and honorary presbyter in the Jamkhed Community Church. She and Drs. Raj and Mabelle Arole were recognized as Social Entrepreneurs of the Schwab Foundation of the World Economic Forum in 2001.

As CRHP became more involved in secondary care and conducted more surgeries, the need for an even more advanced hospital increased, and in 2009, with the help of a donor, the Julia Hospital was built for USD $1.7 million, including all equipment. The Julia Hospital has 50 beds, three operating theaters, a lab, a maternity ward, an Intensive Care Unit, an X-ray lab, a labor room, and a pharmacy. It serves a rural, underserved population of roughly 500,000 individuals.

The Julia Hospital provides low-cost secondary care to half a million people in the Jamkhed and Karjat Blocks (approx. 50-km radius) and beyond, 24 hours a day for emergencies and 9am to 5pm for basic outpatient care.

Services are provided to patients on a sliding payment scale: patients pay what they can afford, and for those who cannot afford anything, services are provided free of charge.

The hospital is meant to provide a safe, affordable healthcare to anyone in need regardless of gender, caste, class, age, ability to pay, and mental or physical disability, to further build trust within the community by offering a comfortable and caring environment for medical needs, to promote basic preventive and curative medical care by able family members, and to serve as a training facility for local, national, and international grassroots health workers, medical students, and practitioners.

9. Training and field visit, March 6, 2017

Before noon, we have attended a class presentation and discussion for new trainees who came from an organization from another state. I also present a brainstorming session on factors contributing to be a healthy person, villager and nation at large.

In the afternoon we visited the **Watershed Development and Management**. The intervention of **Watershed Development and Management** is mainly planning: 1. Minimizing ecological degradation by checking soil erosion, conserving rainwater and raising the water table. 2. Attainment of economic and financial sustainability by increasing crop intensity and productivity and greater employment opportunity for the rural poor.

During our visit the farmers who were harvesting the maize during our visit were giving their witness that they had never had earlier to have such a high yield of crops per hectare. They said that we have this due to the watershed development and management intervention.

10. Overview discussions with the top management of Jamkhed Institute

a. Leadership

The Comprehensive Rural Health Project (CRHP), Jamkhed, has been working among the rural poor and marginalized for more than 40 years. Founded by Drs. Raj and Mabelle Arole to bring health to the poorest of the poor, CRHP is an organization that facilitates the empowerment of people to eliminate injustices through integrated efforts in health and development. Pioneering a comprehensive approach to community-based primary health care, known as the Jamkhed Model, CRHP has become a leader in Public Health and development in rural communities within India around the world.

It therefore stays as a charity and independent organization, which has no allocated budget by the Indian Government. Except the Director the existing staffs with full time, part time and volunteers are entitled to work primarily at their assigned task but also to be flexible and responsible once knowledge and skills of others whereby any and any time to be fit for the institutional gaps to support. It seems very unusual but also could be feasible as long as they are proactively preferred work and support the Institute with mutual interest, it would an organization should be benchmarked.

b. Strategic planning

The Institute has its own vision and mission, who aspires that health, should be a fundamental human right. Eliminating injustices, which deny all people access to this right underlies the very essence of the institute work and approach. However, there seems to be no strategically time bounded planning, especially the institute has been discouraged when the villagers were affected by the drought, and it was then rehabilitation of the victims has been resource demanding and another challenge was to take a lesson from this natural disaster.

Cognizant of this, carefully planning on watershed management and agricultural development in order to secure food availability both in quantity and quality has becoming a front line agenda as to sustain the wellbeing of the community. Hence, the Jamkhed management is preferred to be more flexible and tailored with the community priority agenda.

c. Customer and market focus

Jamkhed as a charity institute and would not expect any budget allocation from the Indian government has to endeavor its own income generation to achieve its institutional vision and mission. One of the things is sustaining the wellbeing of the villagers at large through their full participation and involvement. Secondly, providing short course both for domestic and international trainees.

d. Measurement

They do internal external evaluations special on the training relevancy and quality on all beneficiaries, such as VHWs, domestic and international trainees. The outcome and impact of different interventional measures used to be assessed and evaluated accordingly.

e. Analysis and knowledge management

Refreshment trainings and scholar opportunities are facilitated to trainers. There is always a regular follow-up and coaching to have future potential trainers among the volunteers by providing capacity development trainings.

f. Workforce

The workforce is with full time, half time and volunteers who all are in one way or another their prior interest and commitments are very basic than the expected benefits. These are seriously followed by the principle of Jamkhed model and also the culture of the institute.

g. Process management

It has been tailored by the staff and also by the beneficiaries including villager's prior interest. Creating conducive environment to the respective staff to find themselves equally important and responsible for the development of Jamkhed Institute. The Institute highly encourages motivators, innovators and proactive participants to be recognized.

11. Strengths

- It is a breakthrough model of institute for most vulnerable community members.
- Trainings are tailored made, which is primarily focused on the priority agenda of the trainees and very participatory and practical.
- Its reputability has proved to be known throughout the world and sustain since its

establishment.

- Many institutes are specific to few services but what makes Jamkhed to be special is its universality of providing services to the community on behalf of all sectors.
- Its services stretch from villagers' household to international affairs.
- Some other things you observe in Jamkhed Institute is informality with honesty.

12. Threats

- Unpredictable climate change may again cause droughts despite the watershed development management they intervened.
- The growing problem of non-communicable diseases among the community.
- Environmental pollutions due to solid and liquid waste observed in the town and also along the side of the roads to the villages many plastics (bio non degradable) are disposed on the watershed areas, which may influence on residences, trainees, patients and visitors of the Jamkhed Institute.

13. Recommendations

- Appreciating, the contributions, commitment and methods of training of the village health workers, however one is one, there need to have two VHWs per village than having one. There should be one VHW always in the village while one will be at Jamkhed two days per week. It is always to be two when one gets sick or absent due to other commitment beyond her schedules.

- Some of VHWs used to come with their children while they are on the training and this has been affected their full attention to the knowledge and skill they are supposed to master. It would be nice to solve this problem in the future in either of possible means.

- The watershed development and management still needs regular follow up; full awareness and participation of the community members as a must do practices.

- Maintain the current stability and commitments observed and efforts made by the elder ages to be transferred to the younger age of the villagers.

- I may not be entitled to comment on this but due to my heartily respect and appreciation, it would be nice to have young generation as of this days who wish to follow the vision and mission of Jamkhed model to be sustained under your regular follow-up and coaching.

14. Conclusion

I am very much impressed by successful implementation of the Jamkhed's Comprehensive Rural Health Project. I am also glad to have an opportunity to visit the Jamkhed Model, the evolution of a World Training Centre and sharing its rich and valuable experiences. I hope back home I would like to put most of the experiences to be on the ground for the benefit of our community members in respect to their priority health problems and their full participation with fashion and high commitments.

I would also like to welcome your visit Ethiopia, particularly our Institute and will be glad to host you whenever your schedule allows. Let GOD bless the eyes breaker of this Charity, who has been saving the life of many untouched communities members.

15. Acknowledgement

First and formost I would like to acknowledge Directors: Dr. Shobha Arole and Mr. Ravi Arole, Directors CRHP and your management team for accepting my request to visit Jamkhed Institute for CBPHC. My thanks to Ms. Connie Gates, who has been all the time from the first receptions through out my staying in arranging the schedule and introducing the activities.

I also thank Dr. Henry Perry, Technical advisor of IIfPHC and staff member of Johns Hopkins University Bloomberg School of Public Health, for contacting his former colleagues and partners in India.

Last but not least I thank all staff, village health workers, Mobile team members, and instructors particularly, Ms. Shaila Deshpande, for her unreserved, generous and friendly instruction of her trainees and colleagues. It is always good to have such exemplary people for institutional memory.

On behalf of the International Institute for Primary Health Care in Ethiopia and myself, I would like to thank you all for the opportunity you let us to share this very valuable experiences of the evolution of the world training center (Jamkhed Model).

PART TWO:

BRAC CENTRE

(Mar.9-22, 2017)

Briefing about Brac Centre

The Bangladesh Rural Advancement Committee (BRAC) was established in 1972 as a small-scale relief and rehabilitation organization to assist refuges returning from India restore livelihoods in their newly independent country. BRAC then broadened its focus to address the long-term problems of elimination of poverty and empowerment of women and other marginalized people, which have remained the overarching goals of the organization.

During the forty-three years existence, BRAC has expanded to become one of the largest nongovernment organizations (NGOs) in the World, meeting needs of the marginalized people in a holistic manner through multifaceted development activities. BRAC has followed no particular development model. Instead it has created its own "model" of learning through pilot projects, innovative from experience, scaling up to have impact on key development indicators, and responding to emerging challenges.

Over the last four decades BRAC has extended its operation to nearly 70,000 villages in all 64 districts of Bangladesh, employing more than 110,000 staff who, together with many volunteers, has touched lives of some 120 millions people, mostly from low-income households. Since 2002, BRAC has begun its operation beyond Bangladesh to share its development experiences in poverty-stricken and post-conflict countries in Africa and Asia.

Brac works with its Vision to be a world free from all forms of exploitation and discrimination where everyone has the opportunity to realize their potential. Its mission is to empower people and communities in situations of poverty, illiteracy, disease and social injustice. Brac interventions aim to achieve large scale, positive changes through economic and social programmes that enable men and women to realize their potential.

Gender equality, respect for the environment and inclusivity are themes crosscutting all of its activities. To ensure that it is always learning and that it works is always relevant, it has put in place training, research and monitoring systems across all its activities and financial checks and balances in the form of audits. As a knowledge Centre, it has opened its doors to the wider public in an effort to develop national capacity in Bangladesh through BRAC University.

Bangladesh has made remarkable strides in healthcare in the four decades since independence. Since the 1990's maternal mortality has dropped from 574 to 194 deaths per 100,000 live births, and child mortality from 133 to less than 32 per 1,000 live births. Over four decades, the contraceptive prevalence rate has gone up seven to eightfold. In the 1980's, when immunization coverage was two per cent, the shared roles and activities of BRAC and the government improved the status to 70 per cent within the last four years. The current status of fully immunized children is at 86 per cent. Despite the achievements, Bangladesh still suffers a high burden of deaths and diseases. Over 70 per cent of people seek care from informal health care providers and 62 per cent of those health providers practicing modern medicine have little or no formal schooling. One third of births take place at home, mostly assisted by unsupervised, untrained birth attendants. Recognizing these problems, it has created a pool of frontline community health workers, the shasthya shebikas and shasthya kormis, who strive to address the crisis of human resources in the health sector by playing a substantial role in providing accessible and affordable services to the majority of the population.

In Bangladesh, about one-third of the population lives in urban areas with worse health situation in

slums and squatters in cities. To improve the health status of the slum population, particularly women and children, BRAC started Manoshi, a community based healthcare programme, in 2007 at urban slums of nine city corporations around Bangladesh through development and delivery of an integrated, community-based package of essential health services.

Goal

To decrease illness and death in mothers, newborns, and children in urban slums of Bangladesh

Objectives

Increase knowledge of individuals, households and community

Increase skills and motivation of human resources to offer services at household and community

levels

Improve and strengthen referral system for management of complications • Strengthen and sustain linkage with government, NGO and private health facilities • Develop a supportive network to support communities and individual households to sustain services • Facilitate scaling up of successful approaches

Manoshi envisages improvement in the health status of poor urban mothers, newborns and children by bringing healthcare services to their doorstep through our frontline Community Health Workers (CHWs). The shasthya shebikas and shasthyakormis provide antenatal and postnatal care, essential newborn care (ENC) and child health care. Through behavior change communication interventions they motivate, educate and prepare expectant mothers for childbirth, highlighting an array of health issues including maternal and neonatal danger signs, maternal and neonatal nutrition and so on. BRAC Delivery Centres are established within slums to provide intra-natal care to mothers and immediate care to newborns. Emergency obstetric, neonatal and child health complications are referred to the hospital through an established referral system. The community is connected to health facilities via an innovative mobile phone based referral system. Manoshi is currently being

implemented in eleven city corporations.

Manoshi Innovation: m-Health (Mobile Health)

Currently piloted in the urban slums as Manoshi (MNCH Urban) Programme, the initiative intends to digitize the health services by collecting, recording and preserving household information. Thus it creates a real time virtual database. The database helps to speed up service delivery process to the target population.

Improving Maternal, Neonatal and Child Survival Programme

Improving maternal, neonatal and child survival (IMNCS) project is a comprehensive community based health intervention focusing on preventive and curative care with a group of trained community health workers under structured supervision and monitoring system. This comprehensive undertaking is uniquely designed to address the bottlenecks of demand and supply side for ensuring continuum of care from home to hospital. We are reaching around 25 million people living in rural areas of 14 districts (Nilphamari, Rangpur, Gaibandha, Mymensingh, Kurigarm, Lalmonirhat, Faridpur, Rajbari, Madaripur, Magura, Pirojpur, Joypurhat, Shaerpur and Shariatpur) with maternal, neonatal and child health (MNCH) services.

Essential Health Care (EHC)

Essential health care (EHC) is the foundation of BRAC's health programme, combining promotive, preventive and basic curative services. EHC has revolutionized the primary healthcare approach in Bangladesh, reaching millions with low cost basic health services through BRAC's frontline community health workers.

EHC aims to improve reproductive, maternal, neonatal and child health along with the nutritional status of women and children. The programme further aims to reduce vulnerability to infectious, communicable diseases and non-communicable diseases. The programme provides primary healthcare services including maternal and child healthcare, basic treatment for acute respiratory

infections (ARIs) and promotes family planning methods and safe delivery practices. Use of proper sanitation, safe drinking water, and hygiene-specific messages are also disseminated among communities.

Non-Communicable Disease (NCD) Programme

Non-communicable diseases (NCDs) commonly occurring amongst the people of 35 years and above, require a large quantum of health and social care, irrespective of socio- economic status. Most NCDs are chronic debilitating disease associated with a range of severe complications. Bangladesh has a large number of people living with NCDs. BRAC is going to undertake NCD pilot initiatives in 3 sub-districts of two districts (Narayanganj and Narsingdi) under EHC and 8 sub-districts of 5 districts under Leeds University COMDIS study project. Initially there will be screening, referral and follow up of hypertension and diabetes patients in the community.

MIS and Quality Assurance Unit

The MIS and Quality Assurance Unit (MIS) provide support to improve the quality of the BRAC Health, Nutrition and Population programme (HNPP). Aligned with the monitoring & evaluation (M&E) framework, the MIS unit was formed in 2006 by combining MIS units of different programmes, namely of HNPP and Quality Assurance Cell of EHC. In 2007, a monitoring unit was formed for IMNCS, followed by WASH, Manoshi and Alive & Thrive programmes. In October 2014, the unit was renamed the 'MIS and Quality Assurance Unit'.

Water Sanitation and Hygiene Overview

Active since 2006, the BRAC WASH programme provides hygiene education and increased access to water and sanitation in 250 sub-districts of Bangladesh. It also complements efforts of the Bangladesh government in its water and sanitation interventions. As of December 2015, the programme has currently provided access to hygienic latrines for 41.6 million people, safe water options for 2.3 million people, and hygiene education to an estimated 13.9 million people per year in communities and 2.9 million people per year in schools on average.

Training of teachers and hygiene lessons

In order to sustain good hygiene practices, WASH conducts hygiene sessions through school teachers on a monthly basis. One male and one female teacher from each school are trained on WASH activities and teaching methodology. The teachers are provided with specially designed flip charts and posters in order to educate their students on health and hygiene issues. They develop an action plan for effective implementation of and follow-up on WASH activities, and are assisted by BRAC's WASH staff when required.

Innovation and learning

Innovative activities have been undertaken to develop a sustainable and scalable model of operation that delivers cost-effective sanitation services and technology. BRAC WASH looks into new horizons and focuses on innovation and development of learning tools to further improve the effectiveness and efficiency of its activities. The programme has taken on several different action research projects in this regard.

Reuse of faecal sludge as organic fertiliser

All over Bangladesh pit latrines are filling up, and the waste is being dumped unsystematically. The WASH programme has taken on this challenge in order to avert a probable environmental issue resulting from it. A team from the programme has been exploring various ways to solve this matter. The most reasonable solution is reusing the pit content as organic fertiliser. The study has covered seven climatic zones of Bangladesh, and field trials have been conducted with vegetables and rice paddy to see if it is suitable for human consumption.

Feasibility study on the bioenergy project

Biosol Energy Limited on behalf of BRAC WASH has carried out action Research on Commercially Viable Biogas System Using Feca Sludge and other Agricultural Residues in Bangladesh. The objective was to test the commercial viability of producing biogas and organic fertilizer from faecal sludge on a large scale. Researchers tested the collection procedures for faecal sludge through the use of vacutugs in three different sub-districts of Bogra, in northern Bangladesh. It also piloted the collection of chicken manure and corn stoves. The study checked the feasibility of producing 400kW of energy and estimated that it would be profitable to run a plant on that.

Supply chain

To ensure that customers have access to low-cost, good quality sanitation products in rural areas, especially the more remote ones, BRAC WASH undertook supply chain management. The main purpose of this chain is to facilitate better functioning of the RSCs. These are usually the primary sources of sanitation materials in rural Bangladesh. Sanitation entrepreneurs are provided with training, which emphasizes on the quality of production, as well as building their capacity by focusing on book keeping, administration and marketing skills. Beyond that, much effort is taken to strengthen linkages between communities and RSCs as well as the local government institutions (LGIs).

Qualitative information system

In order to see the real impact of the WASH programme, BRAC and IRC have jointly developed and applied the qualitative information system (QIS) to measure the progress achieved in terms of outcomes. QIS quantifies qualitative process indicators, such as participation and inclusiveness, and outcome indicators, such as behavioral change, with the help of progressive scales (or 'ladders'). Each step on the ladder has a short description, called a mini-scenario, which describes the situation for a particular score. The data is collected on smartphones by trained quality controllers. Further information on QIS is available here.

WASHCost

WASH Cost is a way for BRAC WASH to analyze expenditures, service delivery, and the outcomes achieved as a result of those services. It allows for a financial sustainability check by taking into account all aspects of a service, from initial construction to ongoing maintenance and eventual replacement.

Strengths

- It has more than 45 years experiences serving the community at large
- It has been said that it is the largest NGO in the world and very independent organization
- It has very rich experience of providing training from local to international level of trainings

- Its reputability has proved to be known throughout the world and sustain since its Establishment.
- Its universal supporting of the community is very admirable. For instance health service at the Rural community, Microfinance training and also supporting and short course trainings for Capacity strengthening.
- Its services stretch from villagers' household to international affairs.
- BRAC producing and accessing some of community need supplies with fare price.

Recommendations

- There should be a system, which can control and prove the quality of service and hospitality provided by the BRAC staff meeting with the vision and mission of the institute.
- BRAC is expected to influence on government policies, as far as it proves by its research.

Conclusion

I am very much impressed by successful implementation of the BRAC Centre. I am also glad to have an opportunity to visit the BRAC Centre, as the largest NGO in the World. I appreciate its commitment and capacity as well regarding accessing some of the materials to the community with fare prices.

It should be benchmarked that what BRAC involves in many aspects of the gaps where community members are really need to be assisted. One of its measure task is training, this is very important as long as the need of the training is well identified and addressed to fill the gaps.

Acknowledgement

First and foremost I would like to acknowledge Directors: Dr. Sabina Faiz Rashid, Dean and Professor, James p Grant School of Public Health, for accepting my request to visit BRAC Centre and send an invitation letter. Dr. Mushtaque Chowdhury, vice chair, for welcoming and valuable discussions we made at the very start of my visit. My thanks to Prof. Syed Masud Ahmed, Director, Centre of Excellence for Universal Health Coverage, who invited me to made a presentation to the graduating clss of BRAC University MPH students and the respective faculty members. We also had very valuable discussions about their MPH program. I appreciated the interest and questions raised by the students and staff during my presentation. I would like to appreciate Mr. Syed Sadek Hussain, Manager, and Protocol, who were responsible to facilitate my requests to his respective task as a support.

I also thank Dr. Henry Perry, Technical advisor of IIfPHC and staff member of Johns Hopkins University Bloomberg School of Public Health, for contacting his former colleagues and partners in Bangladesh.

Last but not least I thank all staff in BRAC Centre, village health workers, Mobile team members, and instructors particularly, Dr. Mahmood Kazi Mohammed, Senior Medical Officer Health, Nutrition and Population for his unreserved, generous and friendly greetings and clear instruction and discussions we had together. He was very responsible and also respectful. It is always good to have such exemplary people for institutional memory.

On behalf of the International Institute for Primary Health Care in Ethiopia and myself, I would like to thank you all for the opportunity you let us to share this very valuable experiences of BRAC Centre.

PART THREE:

icddr,b

Briefing about Icddr,b

International Centre for diarrhoeal Diseases research in Bangladesh (Icddr,b) was established in Dhaka in 1960s as the South-East Asia Treaty Organisation (SEATO) Cholera Research Laboratory.

The Cholera Research Laboratory (CRL) soon developed an international reputation in diarrhoeal disease research. During the 1960s, the CRL also established a large-scale health and demographic surveillance site at Matlab – now the longest running such site in the global south and an inspiration for many similar sites worldwide.

In 1962, the CRL established the Dhaka hospital, , still run by icddr,b, to meet the urgent need to treat patients, particularly young children, with severe diarrhoeal disease. The Dhaka Hospital has developed into a nationally important treatment centre and provides an infrastructure for an extensive programme of clinical research. Clinical services were also introduced at Matlab Hospital.

As many other factors affect the risk of diarrhoeal diseases or recovery from them – including nutritional status, income, education of mothers, access to clean water, sanitation habits and efficacy of vaccines – research at CRL expanded into new areas of public health. However, it retained its primary focus on evidence-based solutions able to deliver significant public health benefits at low cost to those living in poverty.

Bangladesh, committed to solving public health problems facing low- and middle-income countries through innovative scientific research – including laboratory-based, clinical, epidemiological and health systems research. For more than 50 years, It has been been carrying out high-quality research and promoting the uptake of evidence-based interventions. Its initial focus was on diarrhoeal disease, but it is now studying multiple infectious diseases, other threats to public health, and methods of healthcare delivery. Its work has had a profound impact on health policy and practice both locally and globally – and this remains its key objective for the future.

Strategy

Its vision is a world in which more people survive and enjoy healthy lives. **Its mission** is to solve key public health problems through innovative scientific research. It has values on:
excellence, Integrity, and Inclusivity,

Its objectives

Its Strategic Plan 2015–2018 also identifies six goals to guide our activities in the short term:

- Implement a focused research strategy
- Increase the visibility and impact of our research evidence
- Invest in our research platforms
- Invest in our people
- Improve organizational efficiency and cost-effectiveness
- Ensure financial sustainability

Approach

icddr,b is set of key principles: Understanding local context; Developing practical solutions; Generating evidence to support wider use; Focusing on translation; Networking globally; Building an infrastructure for world-class research; Liaising with Government;

Our major achievements

- Oral Rehydration Solution
- Zinc Treatment for Diarrhoea
- Tetunus Toxoid Vaccine for Mothers
- Guidelines for Treating Severe Malnutrition
- Testing Vaccines
- Family Planning Solutions
- Domestic Violence Legislation
- Continuing innovation
- Mat for Measuring Maternal Blood Loss
- Ultra Low-cost CPAP Device for severe pneumonia
- Supplementary and therapeutic foodstuffs to prevent and treat malnutrition

Research

It is focused on seven areas of unmet need of particular relevance to low- and middle-income countries. Our studies in Bangladesh take advantage of an extensive research infrastructure, including high-quality laboratory facilities, a major hospital and other clinical facilities, and multiple well-established field sites. We also maintain multiple collaborations with research groups and implementing partners in both the global North and the global South.

Maternal and neonatal health

1. The global and local context of maternal and childhood malnutrition

The situation in Bangladesh

In Bangladesh, more than half the population suffers from malnutrition. Severe acute malnutrition affects 600,000 children; while close to 2 million children have moderate acute malnutrition.

Stunting affects 40% of children under the age of five. A quarter of women are underweight and around 15% have short stature, which increases the risk of difficult childbirth and low-birth-weight infants. Half of all women suffer from anaemia, mostly nutritional in origin. Malnutrition is estimated to cost Bangladesh more than US$1bn every year in lost productivity.

Our achievements in maternal and childhood malnutrition research

- **Ready-to-use supplementary and therapeutic foods**
- **Nutrition policy development**

In Bangladesh, we led the development of the National Nutrition Policy and reviewed the nutrition background paper that will inform the country's seventh Five Year Plan.

Maternal and childhood malnutrition

Malnutrition remains a major public health issue in Bangladesh and other south Asian countries. We have developed ready-to-use supplementary and therapeutic foods (RUSF and RUTFs) based on locally available ingredients (such as rice, lentils and chickpeas). We have been evaluating their acceptability to children and efficacy, and examining their impact in field trials. In clinical trials we are also evaluating other possible treatments to prevent childhood stunting and to address maternal malnutrition.

We are working with the Government of Bangladesh to evaluate pilot schemes implementing treatments for moderate and severe childhood malnutrition. We are also analysing barriers to the effective implementation of maternal nutrition programmes. We have also provide important input into national nutrition policy – programme lead Dr Tahmeed Ahmed was chair of the drafting committee.

Emerging and re-emerging infections

We use our understanding of likely routes of infection transfer to develop new interventions. We aim to identify methods that are practical and affordable, and so would be suitable for wider scale-up. For example, we have developed bamboo skirts to prevent contamination of date palm sap with bat saliva and urine, an important route for Nipah transmission to humans. We are also working on interventions to limit spread of avian influenza in live bird markets.

We are evaluating a range of strategies to prevent disease transmission. These include vaccination of people and of potential reservoir organisms (e.g. cattle for anthrax, pigs for Japanese encephalitis). We are also evaluating communication campaigns to reduce the risk of Nipah infection. We routinely respond to infectious disease outbreaks in Bangladesh in partnership with the Institute of Epidemiology, Disease Control and Research (IEDCR), and in collaboration with the local One Health initiative.

The situation in Bangladesh

Bangladesh provides opportunities to study emerging infections and their transmission within animal populations, from animals to humans and from person to person. As well as helping to control infections locally, such work has a vital role to play in identifying and containing emerging and re-emerging infections, including drug-resistant agents that pose a regional and global public health threat. (

Dengue is common in Dhaka and an emerging risk in rural areas. Nipah virus causes yearly outbreaks of encephalitis in Bangladesh, with more than 75% case fatality. Avian influenza is endemic in Bangladeshi poultry, but has thus far caused only mild illness in humans. Yearly outbreaks of anthrax occur in ruminants such as cattle, with some human infections. Behavioural change interventions to prevent cross-species transmission are often hampered by local poverty and food insecurity.

Multidrug-resistant tuberculosis (MDR-TB) is common in Bangladesh, and the infrastructure to treat MDR-TB is limited. Global spread of antibiotic-resistant bacteria and malaria, some originating from South Asia, has caused international concern and Bangladesh is seen as one of the crossroads between Asia and Africa for their spread.

Our achievements in controlling emerging and re-emerging infections

- **Human avian influenza infection**
- **Nipah prevention intervention**

Universal health coverage

We evaluate gaps in access, delivery, quality, financing, policy and governance in the health sector in Bangladesh, and test interventions to remedy deficiencies.

icddr,b is committed to the principle that all people, irrespective of their social and economic position, should have access to affordable, acceptable, high quality and responsive health care. The conceptual framework for our work is provided by the six building blocks of health systems identified by the WHO:

- Service delivery (
- The health workforce (
- Information systems (
- Medical products (
- Financing (

Leadership and governance(

They have particular expertise in areas such as urban health, health care financing mechanisms, gender-related issues, innovative use of new technologies, implementation research and systematic reviews, strengthening capacity building of the national health programme, and demographic surveillance. (

The situation in Bangladesh

Several factors contribute to the lack of universal health coverage in Bangladesh. With only 0.5 doctors and 0.2 nurses per 1000 people, far below WHO recommended levels, the country's

human resources for health are at crisis levels uneven distribution of the health workforce, and issues of retention and overwork, will require innovations in capacity building, incentives and task shifting the lack of effective regulatory systems contributes to poor quality services and a large informal sector catering to the poorest in society high out-of-pocket health care expenditures create financial barriers for those least able to afford the cost of health care.

Our achievements in universal health coverage

Our work has fed into policy-making and the planning of healthcare service delivery in Bangladesh. Our studies have generated evidence to support policy-making as well as tools to facilitate the planning of healthcare services. We have also provided direct input into policy-making, for example feeding into the Government of Bangladesh's first healthcare financing strategy. Examples of our achievements include:

- GIS mapping of healthcare facilities
- Women's rights

Non-communicable diseases

Research goals in non-communicable diseases

The global and local context of non-communicable diseases

The situation in Bangladesh

All major risk factors for NCDs are widespread in Bangladesh, including tobacco use, inadequate intake of fruit and vegetables, low physical activity, obesity and high blood pressure. NCDs are estimated to account for 59% of total deaths in Bangladesh.

In response to this growing threat, Bangladesh has developed a national strategy for surveillance and prevention of non-communicable diseases. A dedicated unit has been established within the Ministry of Health and Family Welfare, with new service delivery options being piloted.

Our achievements in non-communicable disease research

- Documenting the rise of childhood obesity
- Raising awareness of hypertension awareness

Conclusion

I am very much impressed by successful implementation of the Jamkhed's Comprehensive Rural Health Project. I am also glad to have an opportunity to visit the Jamkhed Model, the evolution of a World Training Centre and sharing its rich and valuable experiences. I hope back home I would like to put most of the experiences to be on the ground for the benefit of our community members in respect to their priority health problems and their full participation with fashion and high commitments.

I would also like to welcome your visit Ethiopia, particularly our Institute and will be glad to host you whenever your schedule allows. Let GOD bless the eyes breaker of this Charity, who has been saving the life of many untouched communities members.

Acknowledgement

- First and formost I would like to acknowledge Directors: Dr. Shobha Arole and Mr. Ravi Arole, Directors CRHP and your management team for accepting my request to visit Jamkhed Institute for CBPHC. My thanks to Ms. Connie Gates, who has been all the time from the first receptions through out my staying in arranging the schedule and introducing the activities.

- I also thank Dr. Henry Perry, Technical advisor of IIfPHC and staff member of Johns Hopkins University Bloomberg School of Public Health, for contacting his former colleagues and partners in India.

- Last but not least I thank all staff, village health workers, Mobile team members, and instructors particularly, Ms. Shaila Deshpande, for her unreserved, generous and friendly instruction of her trainees and colleagues. It is always good to have such exemplary people for institutional memory.

On behalf of the International Institute for Primary Health Care in Ethiopia and myself, I would like to thank you all for the opportunity you let us to share this very valuable experiences of the evolution of the world training center (Jamkhed Model).

Strengths

- It has more than 45 years experiences serving the community at large
- It has very rich experience of providing community services and conducting researches, Trainings and also producing vaccines.
- It is a breakthrough model of institute for most vulnerable community members.
- Its reputability has proved to be known throughout the world and sustain since its establishment.
- Its reputability has proved to be known throughout the world and sustain since its Establishment.
- Its universal supporting of the community is very admirable. For instance health service at the Rural community, Microfinance training and also supporting and short course trainings for Capacity strengthening.
- Its services stretch from villagers' household to international affairs.
- Icddr,b conducting very high level researches and also known for treating diarrheal cases at the Hospital level.

Threats

- The community who need clinical service support both at the icddr,b Centre in Dhaka and At Matlab research and health service Centre are not paying at least with minimal fee, this may affect the sustainability of the institutional service in the future as the service demand by the community is going to be increasing in the future.

- The icddr,b does not have financial independency so far, unless it would be corrected, it may be challenge the future service to sustain as it has been earlier.

Recommendations

- Appreciating, the contributions, commitment and methods of community services are provided by icddr,b but there must be a reasonable fee for the services in the future.

- Maintain the current stability and commitments observed and efforts made by the clinical staff in the diarrheal Centre

- Icddr,b is expected to influence on government policies, as far as it proves by its research.

Conclusion

I am very much impressed by successful implementation of the icddr,b. I am also glad to have an opportunity to visit the icddr,b, as the world class diarrheal disease control Centre. I appreciate its commitment and capacity as well regarding accessing some of the materials to the community with fare prices.

It should be benchmarked that what icddr,b involves in many aspects of the gaps where community members are really need to be assisted. One of its measure tasks is community services and researches particularly in health services areas.

Acknowledgement

First and foremost I would like to acknowledge Prof. John D Clemens, Executive Director, for accepting my request to visit icddr,b and send an invitation letter. Dr. Shams El Arifeen, Senior Director and Senior Scientist, for welcoming and valuable discussions we made at the very start of my visit. My thanks to Dr. Twaha Mansurum Haque, Program manager, coordination, Centre for Child and Adolescent Health, and Dr. Chandra Shakhar Das, Senior Medical Officer, for their unreserved support, who were with me resourcefully and respectfully explained and introduced the whole my scheduled visit.
I also thank Dr. Henry Perry, Technical advisor of IIfPHC and staff member of Johns Hopkins University Bloomberg School of Public Health, for contacting his former colleagues and partners in Bangladesh.

Last but not least I thank all staff in icddr,b, village health workers, Mobile team members, and the Matlab research and health service Centre staff for their very blessed and very valuable service for the community at large.

On behalf of the International Institute for Primary Health Care in Ethiopia and myself, I would like to thank you all for the opportunity you let us to share this very valuable experiences of icddr,b.

PART FOUR:

SUMMARY TABLE

Brief descriptions by comparing four institutes
March 1-30, 2017

	I-PHC-Ethiopia	Jamkhed - India	BRAC-Bangladesh	Icddr,b_Bangladesh
Vision	Contribute to the revitalization of the Global movement of "health for all" through Primary health care.	to facilitate and empower the poor and marginalized & Enable them to achieve their full potential Through a value-based approach with equity and justice.	A world free from all forms of exploitation and discrimination where everyone has the opportunity to realize their potential.	A world in which more people survive and enjoy healthy lives
		By mobilizing and	to empower people and	

Mission	To provide training on Primary health care and conduct PHC research.	building the capacity of communities all can achieve access to health care and freedom from poverty, hunger and violence.	communities in situations of poverty, illiteracy, disease and social injustice. Our interventions aim to achieve large scale, positive changes through economic and social programmes that enable men and women to realise their potential.	To solve key public health problems through innovative scientific research
Years of experiences	1 (since February 2016)	47 yrs. (since 1970)	45 yrs. (since 1972)	57 (since 1960)

	I-PHC-Ethiopia	**Jamkhed – India**	**BRAC-Bangladesh**	**Icddr,b_Bangladesh**
Short description of each institute	Established less than 2 years ago found in a preparatory phase need to be established as an independent institute to sign project agreements and also to have a clear authority and accountability.	Established as a family charity organization and still goes with the same trained with strengthening its partnership capacity nationally and international. It has been recognized world wide for its institutional objective success.	Because of its multi-sectorial engagement and contribution to societal development work it has been considered as one of the larges NGO in the world. It has been recognized worldwide for its competency and significant contributions.	It is known world wide and also recognized by WHO for its long years service specially in Diarrheal disease management, and also for their best research outcome such as vaccine production and many others blessed contributions as center of excellence.
Inst. objectives	1st: Training	1st: Community	1st: Training	1st: Clinical services

in order of their Focus	2nd: Research 3rd: Community services 4th: Conference facilitation	services 2nd: Training 3rd: Community participation 4th: Research	2nd: Community services 3rd: Marketing 4th: Evaluation & Res.	2nd: Rural community services 3rd: Research 4th: Training
Accountability	To the Federal ministry of health, Ethiopia, It is on progress to established as an independent institute.	Established as charity organization independently	Formed as an Non Governmental organization (NGO)	Dependent to the Government but there are exempted from Governmental tax and also allowed to use some of their income as a revolving fund

	I-PHC-Ethiopia	**Jamkhed –India**	**BRAC-Bangladesh**	**Icddr,b_Bangladesh**
Best practices	• Health system structuring by the government • Political commitmen t to HEW Selection criteria of HEWs in the rural community	• Frequent training & Participatory appraisal methods • Role of mobile team Community development work	• Microfinance support • Marketing & accessing different supplies to the community • Its universal engagement Independent resources	• Unreserved support of clinical services • Uninterrupted research engagement Community development work
Some Drawbacks observed during the visit	Lack of clear directions about financial management and accountability	There is no a formal schedule and strategy plan to be referred	Only focusing on their strategy than supporting and following the governmental	Limited on their catchment population and low-income schemes.

			structure	
Requires to be improved	• Increase commitment of HEWs • Very close follow up of HEWs • Continuing need based trainings Conducting evaluation studies	• Sustain a revolving fund • Needs more focus towards young age groups attitude • Planning for project sustainability	• Critically evaluate its own working force attitude Needs to be more engaged in research & support the policy makers and existing structure of the Government	• Needs to work own for its financial independency • Work own better means of income generation • Make sure their research outcome influences the policy makers

Note: Both BRAC and Icddr,b have 4-5 health providers at the community level, that means one is for EPI, the second person for MCH & FP, and the rest, most of them have very short periods of training not more than 3 months. Each of them is expected to summit reports to their respective offices. The government is also expecting reports from its assigned health providers. During this time duplication of efforts and doubling of reports could also be a problem at the end of the day, its very unlikely to have a real report that would reflect the actual figures. It is therefore strengthening and supporting the government structure and centralizing the reporting method would be very nice, at the same time having two health providers who have a one-year similar training and assigned at the lowest level of clinic would be much better than having 4-5 people at one place for different specific tasks. The two health providers maintain at least one person to be in the clinic while one would not be at the clinic.