



International Institute for
Primary Health Care in Ethiopia

Trip Report: Benchmarking visit to India and Bangladesh



February 28 – 23 March 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
IPHC	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
WSHG	Women's Self-Help Groups

Introduction

I. The International Institute for Primary Health Care in Ethiopia, IPHC

On February 1, 2016, the Ethiopian Federal Ministry of Health (FMOH) established and inaugurated the International Institute for Primary Health Care in Ethiopia (IPHC). This Institute has been founded with an optimistic vision of revitalizing the Global movement “Health for ALL” through Primary Health Care. International Institute for Primary Health Care in Ethiopia (IPHC) put together a one-year operation plan currently under implementation. The project is funded by the Bill & Melinda Gates Foundations. Included in the operation plan was the activity of best practice benchmarking in order to identify world-class examples of similar functioning organizations to learn from and increase the efficiency and effectiveness of the IPHC. In addition, the benchmarking serves as a way of discovering new developments regarding primary health care in other countries and then use the information to strengthen Ethiopia’s own health policy. IfPHC carries out the benchmarking, in conjunction with Johns Hopkins University Bloomberg School of Public Health.

2. Pre-benchmarking preparatory measures

2.1. Selection criteria of institutes to be benchmarked

Dr. Henry Perry, technical advisor of IPHC and staff member of Johns Hopkins University Bloomberg School of Public Health, contacted his former colleagues and partners in Bangladesh and India. He selected the Jamkhed Model also known as Comprehensive Rural Health Project from India, Bangladesh Rural Advancement Committee (BRAC) and the International Centre for Diarrheal Disease Research from Bangladesh as benchmarking site for IPHC. The three organizations were contacted and visits were scheduled for February 28 to March 30, 2017.

2.2. Method of benchmarking

To benchmark critical areas, IPHC used the business excellence model that is developed by Malcolm Baldrige. The model is a set of inter-related criteria that aims to capture key aspects of any successful organization. Baldrige 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
Flew to Pune
4 hours drive to Jamkhed
Meeting with Jamkhed's staff

Tuesday Mar.9:

Travel from Mumbai to Dhaka, Bangladesh

Wednesday Mar 22, 2017:

Travel from Dhaka, Bangladesh to Mumbai, India

Thursday Mar.30, 2017

Travel from Mumbai, India to Addis Ababa, Ethiopia

Main Findings/Issues

I. JAMKHED MODEL, India

(Mar.1-8, 2017)



Founders of the Jamkhed Model, Drs. Raj and Mabelle Arole

I Brief description of Jamkhed Model

For the past 47 years, the Comprehensive Rural Health Project (CRHP), also known as Jamkhed, has been working among the rural poor and marginalized. 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, 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.

2 My journey in Jamkhed

a. March 1,2017: Meeting with the staff of Jamkhed model

When I arrived in Jamkhed I first met with Ms Connie Gates, and Dr. Raj.

Ms. Connie Gates is an American Representative for Jamkhed. In 2003, Connie established Jamkhed International – North America (JINA), an organization, which promotes the Jamkhed model among NGOs, church organizations, and student and professional organizations. She was introduced to community-based primary health care and CRHP, Jamkhed, India, in 1972 by Dr Raj Arole, which inspired her to pursue this field as her career.

She invited me to watch a short footage on the historical development of the Jamkhed model. She also provided me with a three-week course timetable on Primary Health Care used by the Jamkhed Institute.

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

Village Health Workers provide basic preventive healthcare and knowledge to their relevant 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 to deliver if they choose to do so or if it is medically necessary.

Village Health Workers are expected:

- 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), commonly illiterates 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

collectively and responsibly work with Mobile team workers.

Ms. Connie Gates and Ms. Shaila Deshpande and myself went to Padali village, which is 20 kms away 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 Dr. Raj Arole addressing 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 detecting the early warning signs and symptoms of diabetes as well as on diabetes prevention and control. I also had the chance of meeting with mobile team members one of whom has been serving since 1974, four years after the Jamkhed model established in 1970.

In the Jamkhed library, I had the liberty to watch two documentary films about the Jamkhed International training, testimonials of many national and international visitors talking about the very successful Jamkhed model and the Society for Elimination of Rural Poverty (SERP) project put in place in the whole state of Andhra Pradesh. Ms. Connie Gates handed me a book about Jamkhed Model for IPHC resource centre. Later on that evening, I met with Mr. Ravi Arole and we sat down to plan the tentative schedule for the upcoming two consecutive days.

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, Ravi returned back to India in 2005. Since then he has been the Director of Operations, of CRHP and of the Jamkhed Institute.

During our visit at the Padali village, we met with one village health worker elected by the village community and another women, who is a health worker assigned by the government. We all went to the house of the VHW, where she demonstrated and explained the activities she provides to the community. All of our questions regarding her and her family where also answered and clarified by the VHW.

Among the many skills she possessed, we where able to witness her ability in taking blood pressures, consulting pregnant ladies, screening for diabetic patients and high risk pregnancy.

The village health worker works cooperatively with the health agent assigned by the government. Guided by both of them, we headed to the government childcare center (no – it's preschool program), which is a child feeding and growth-monitoring center of the village. Here, we had the chance to witness the use of different charts, instruments, playing materials, formulated food for children, pregnant and lactating mothers.

All or most of the original VHWs were illiterate, who are committed to proudly support the villagers. The skills and knowledge that they have acquired were beyond our expectations. The VHWs, selected and valued by the villagers are expected to start their family in the village itself and be committed to help the villagers at all times. The founder of the Jamkhed Model speaks highly of the VHWs and is proud of their commitments and achievements.

c. Women's Groups

- **Women's Self-Help Groups (WSHG)** 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.

I attended a group presentation and discussion on diabetes conducted among **25-community health workers** who were there representing their respective villages. These community health workers are Jamkhed Institute graduates who used to attend trainings twice every week at the Institute.

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 had the chance of sitting down with a mobile health team member for a brief discussion. At the end of our conversation, I realized how crucial the role of MHTs was in transferring information, technology and any social development activities to remote areas and also in empowering women at large in the society.

d. The Mobile Health Team, March 3, 2017

During our one-on-one discussion with a Mobile Health Team member, I was able to understand in-depth their contribution to improving the health of the villagers. The Mobile Health Team helps train Village Health Workers and work side by side with them to provide health services to villagers. 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 the health center's Julia Hospital, the third and final level of the referral system. If a patient cannot be treated in the field, he or she has the option of coming to the 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 volunteered workers for the Jamkhed Institute. Jamkhed has however considered providing them with some benefit packages.

e. Attending and Providing Trainings, March 3, 2017

i. Observations of VHWs trainings 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. These trainings are provided twice a week at the Jamkhed Institute. 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 with skills and knowledge to function as primary health care workers. The VHWs come together weekly for CRHP-based training to review skills, share stories, and update statistics.

While I had the chance to witness one of these trainings, I observed a class of 25 VHWs divided in groups of five, and conducting discussions on diabetes. I was amazed by the way they delivered very effective presentations regarding signs, symptoms, preventions, diagnosis, screening, control and dieting of Diabetes Mellitus. I was informed that they stayed up for two consecutive days prior to the training studying and talking about diabetes. During the training there were a lot of brainstorming's, debates, role-plays, drama activities, discussions around culturally sensitive issues and talks about challenges during screening and diagnosing of patients.

The discussions ended with a concise summary of solutions for better outcomes and big rounds of applause to all the participants with the presence of the mobile team and the instructors who have been coaching and guiding the VHVs. Such knowledge and skill is expected to be implemented under the supervision of Mobile team members and also transferred by the VHVs to women's self help groups in their respective village.

ii. 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. This type of training has dual advantages: to build up a positive reputation for the institute and become a source of income for further sustainability of the institute.

iii. 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.

Overall, 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.

Unfortunately, during my visit, there wasn't any international trainings that were taking place. However, I met with two foreign volunteers, financially supported by their respective home town institution, who were actively involved in the activities of the Jamkhed institute while also learning a lot from the model. These two volunteers have completed their post and undergraduate courses and will be in Jamkhed for few more months.

f. Farm field visit, March 4, 2017

On Saturday March 4, 2017, we went to Khdkat Farm. 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. The Farm is also believed to provide 70 to 80 percent of food demands for the CRHP campus training center, living quarters, and preschool, which drastically reduce overall CRHP costs. It is assumed that Khadkat Farm will 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 as well.

g. Weekend break, March 5, 2017

Visited the Saurada waterfall near Jamkhed, about 20km to the north.

h. Julia Hospital visit, March 6, 2017

On Monday March 6, 2017, I visited to Julia hospital in Jamkhed guided by Dr. Shobha Arole, who is co-director of CRHP.

Dr. Shobha Arole was born on February 2, 1961 in Kolar, India. Growing up between the U.S. and India like her parents (Drs. Raj and Mabelle Arole) who 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.

i. Training and field visit, March 6, 2017

On March 6, 2017, just before noon, I attended a class presentation and discussion for a new set of trainee who came from an organization located in another state in India. I also had the opportunity to start a brainstorming session with the participants on factors contributing to healthier villagers and nation at large.

In the afternoon we visited the **Watershed Development and Management**. The intervention of **Watershed Development and Management** is mainly planning:

- I. 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 confirmed that they have never had such an early high-yielding crops per hectare. They explained that this large achievement in agriculture is due to the watershed development and management.

3 Overview of discussions conducted with top management of Jamkhed Model.

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 a 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 in covering other tasks, when need arise, in order to fill any intuitional gap. It seems very unusual but also feasible as long as they is commitment and support of the Institute with mutual interest.

b. Strategic planning

The Institute has its own vision and mission, that 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. The Jamkhed area was hit by a

prolonged drought for several years, which impacted the life of the villagers. This insidious hazard of nature took a toll on the institute. For quite sometimes after the drought, the institute had become a rehabilitation center for the villagers who were mostly affected by this phenomenon which cost the institute a lot of money and resources. However, there were a great deal of operational lessons learned in disaster response.

Cognizant of this, carefully planning on watershed management and agricultural development in order to secure food availability both in quantity and quality has become 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 would not expect any budget allocation from the Indian government. It has to endeavor its own income generation to achieve its institutional vision and mission. One of the objectives 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 and external evaluations, especially on the trainings relevancy and quality in transmitting the intended skills and knowledge effectively to all beneficiaries, such as VHWs, domestic and international trainees. The outcome and impact of the international trainings are also measured, 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 consists of full time, part time workers and volunteers. The commitment of the employees to the core value and objective of the institute largely outweighs their interest in any benefit that the Institute has to offer. They sternly adhere to the principle of Jamkhed model and also the culture of the institute.

g. Process management

The process management has been tailored by the staff and also by the beneficiaries including villager in order to accommodate everyone's interest. The Institute highly encourages and recognizes visionaries, innovators and proactive participants.

4 Strengths of the Jamkhed Model

- It is a breakthrough model of institute based on a comprehensive approach to primary health care at the community level, to address priority health needs; a model that could be adapted to most struggling developing countries.
- Trainings are tailored to the participants needs, interest and as well as the villages health issues that are of great concern.
- The trainings are very participatory and interactive.
- Its reputability has proved to be known throughout the world and has also been able to sustain since its establishment.
- Many institutes are specific to few services but what makes Jamkhed special is its universality in providing services in all sectors of life to the community.
- Their service stretches out from villagers', household to international trainings.
- What makes Jamhed Institute is the fact they are upfront about the work they do and the result they have gotten so far. The Institute will not tamper in data for the sake of propaganda.

5 Weaknesses of the Jamkhed Model

- Unpredictable climate change may again cause droughts despite the watershed development management that the institute invented.
- There is a growing problem of non-communicable diseases among the community that are not efficiently addressed and that are cause for concern.
- 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) or even disposed on the watershed areas, are also cause of health concern for the villagers

6 Recommendations

- While I appreciate, the contributions, commitment and methods of training of the village health workers, I think there should be two VHWs per village rather than just one.
 - There should always be one VHW available in the village and accessible to the villagers while the second one either goes to Jamkhed for trainings twice per week , is out sick or is just absent due to other commitment .
- I also observed that some the VHWs get easily distracted by their children whom they bring with them to the Jamkhed institute, during crucial trainings of essential skills and knowledge. I think the Institute should find a way to accommodate the VHWs with children.
- The watershed development and management still needs regular follow up; full awareness and participation of the community members is essential.
- While maintaining the current commitments and efforts shown by the elders, these obligations should be thought and explained to the youngest generation for further sustainability.

7 Conclusion

I am very much overwhelmed by the successful implementation of the Jamkhed's Comprehensive Rural Health Project. I am also very pleased to have gotten the opportunity of visiting the Jamkhed Model, a true model of an evolutionary Universal Training Centre and also to further share its rich and valuable experiences with whomever is interested. I am very much anxious to get back to my hometown and tailor and implement the best practices and experience that I have come to witness at the Jamkhed Model, in order to benefit our community in need.

I would also like to invite the Jamkhed institute to visit Ethiopia, particularly the International Institute for Primary Health Care in Ethiopia. We would be more than happy to host their visit and show them the same amount of hospitality they have shown me during my stay. Let GOD bless the eyes breaker of this Charity, who has been saving the life of many untouched community members.

8 Acknowledgement

First and foremost I would like to acknowledge Directors:

- Dr. Shobha Arole and Mr. Ravi Arole, Directors CRHP and your team of management for accepting my request to visit Jamkhed Institute.
- Ms Connie Gates, who has been by my side through my journey, scheduling visits within Jamkhed and explaining the different activities.

I also would like to thank Dr. Henry Perry, Technical advisor of IlfPHC and staff member of Johns Hopkins University Bloomberg School of Public Health, for reaching out to his former colleagues and partners in Jamkhed and make this trip feasible.

Last but not least I would like to thank all staff member, village health workers, Mobile team members, and instructors that I have come across during my journey. Particularly,

I would like to thank Ms. Shaila Deshpande, for her unreserved, generous and friendly explanations of her training sessions.

On behalf of the International Institute for Primary Health Care in Ethiopia and myself, I would like to thank you all for the great opportunity of learning from this true model of a evolutionary Universal Training Centre, the Jamkhed Model.

II. BRAC CENTRE

(Mar.9-22, 2017)



Mothers at BRAC learning center discussing and asking questions to the community health workers

I **Brief description of Brac center**

The Bangladesh Rural Advancement Committee (BRAC) was established in 1972 as a small-scale relief and rehabilitation organization to assist refugees 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 of its 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.

a. Manoshi

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 the 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.

b. 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.

c. 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. They 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.

d. 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.

e. 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.

f. 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'.

g. 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.

h. Training of teachers and hygiene lessons

In order to sustain good hygiene practices, WASH conducts hygiene sessions through schoolteachers 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.

i. 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.

j. Reuse of faecal sludge as organic fertilizer

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 fertilizer. 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.

k. 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 Faecal 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.

Checking the critical areas of the business excellence model on Brac Centre

Using the business excellence model and the seven criteria, my findings are the following.

a) Leadership

Because of its strong leadership, 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.

b) Strategic planning

BRAC has not followed a particular development model. Instead, it has created its own “model” of learning through pilot projects, innovating from experience, scaling up to have impact on key development indicators and responding to emerging challenges.

c) Customer and market focus

Supply chain management

To ensure that customers have access to low-cost, good quality sanitation products in rural and remote areas, BRAC WASH undertakes 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. Their capacity is build by focusing on bookkeeping, 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).

d) Measurement, analysis and knowledge management

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.

Information Technology

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'.

In addition, Qualitative Information System (QIS) is used to see the real impact of the WASH programme. QIS has been jointly developed by BRAC and IRC to measure the progress achieved in terms of outcomes. The system 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.

Library

Brac Center has a library at Comilla with huge collections.

e) **Workforce**

As mentioned above, Brac has more than 110,000 staff. Volunteers also support the different programs of the Centre.

f) **Process management**

Innovation and learning

The organization designs, manages and improves its key processes through learning and innovation. For instance, 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.

g) **Results**

Brac Centre is said to be the largest NGO in the world and an independent organization. Its reputation has proved to be known throughout the world. Brac has reached over 120 million people, mostly from low-income households.

Strengths

- Brac Centre has more than 45 years of experience serving the community at large.
- Brac's services stretch from villagers' households to international affairs.
- Brac has rich experience in providing local and international level trainings
- The Centre universally supports the community, which is admirable. For instance, the services for the community include: health service in rural areas; microfinance training and support; and short course training for capacity strengthening.
- BRAC produces some needed supplies and make them accessible to the community at fare price.

Recommendation

- There should be a system to control and prove the quality of service and hospitality provided by BRAC staff.
- BRAC may need to influence government policies based on the outcome of its research.

Conclusion

The successful implementation of the different projects at Brac Centre is admirable. I was privileged to visit BRAC. The commitment of Brac to serve the rural community is high. The supply chain management is also appreciated since it creates access to some materials at affordable costs. This practice needs to be taken up to address demand gaps and community needs.

Brac's major task is providing training. The training program remains important if needs assessment is carried out and training needs are identified to fill the knowledge and skill gaps.

Acknowledgement

My special thanks go to the Directors, Dr Sabina Faiz Rashid, Dean and Professor and James P Grant of School of Public Health, for accepting my request to visit BRAC Centre. I thank Dr Mushtaque Chowdhury, Vice Chair, for welcoming me and for the valuable discussions we have had. My thanks also go to Prof. Syed Masud Ahmed, Director of Centre of Excellence for Universal Health Coverage. He invited me to make a presentation to the graduating class of BRAC University MPH students and to the respective faculty members. We had time to discuss about their MPH program. I

appreciated the interest and the questions raised by the students and staff during my presentation. I also thank Mr. Syed Sadek Hussain, Manager and Protocol, who was responsible for facilitating my program and providing support.

I also thank Dr. Henry Perry, for making the first contact to arrange the benchmarking visit.

I thank all staff members of BRAC Centre, village health workers, mobile team members and instructors. My thank you to Dr. Mahmood Kazi Mohammed, the Senior Medical Officer Health, Nutrition and Population, for the discussions we had together. He was respectful and responsible.

On behalf of the International Institute for Primary Health Care in Ethiopia and myself, I would like to thank you all for sharing your valuable experience.

III. icddr,b



Briefing on Iccdr,b

International Centre for Diarrhoeal Diseases Research in Bangladesh (Iccdr,b) was established in Dhaka in the 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. The site is currently the longest in the global south and is an inspiration for many similar sites worldwide.

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

As many 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 that is 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 carrying out high-quality research and promoting the uptake of evidence-based interventions. Its initial focus was on diarrhoeal disease, but it is currently 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 practices, both locally and globally, which remains its key objective in the future.

Vision and mission

Iccdr,b's 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. The core values are on excellence, integrity, and inclusivity.

Research

Research is focused on seven areas of unmet needs of particular relevance to low- and middle-income countries. The studies in Bangladesh take advantage of an extensive research infrastructure, including high-quality laboratory facilities, a major hospital¹⁰ and

other clinical facilities, and multiple well-established field sites. Icddr,b also maintain multiple collaborations with research groups and implementing partners in both the global North and the global South.

Maternal and neonatal health

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

The situation in Bangladesh

In Bangladesh, more than half of 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.

The achievements in maternal and childhood malnutrition research include:

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

Icddr,b 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. Icddr,b has developed ready-to-use supplementary and therapeutic foods (RUSF and RUTFs) based on locally available ingredients (such as rice, lentils and chickpeas). Icddr,b has been evaluating their acceptability to children and efficacy, and examining their impact in field trials. In clinical trials, the organization is also evaluating other possible treatments to prevent childhood stunting and to address maternal malnutrition.

Icddr,b is working with the Government of Bangladesh to evaluate pilot schemes implementing treatments for moderate and severe childhood malnutrition. The organization is also analysing barriers to the effective implementation of maternal nutrition programmes. Icddr,b has also provided important input into national nutrition policy – programme lead Dr Tahmeed Ahmed was chair of the drafting committee.

Emerging and re-emerging infections

Icddr,b uses its understanding of the likely routes of infection transfer to develop new interventions. It aims to identify methods that are practical and affordable, and so would be suitable for wider scale-up. For example, Icddr,b has developed bamboo skirts to prevent contamination of date palm sap with bat saliva and urine, an important route for Nipah transmission to humans. The organization is also working on interventions to limit spread of avian influenza in live bird markets.

Icddr,b is 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). The organization is also evaluating communication campaigns to reduce the risk of Nipah infection. Icddr,b is routinely responding 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

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.

Icddr,d's achievements in universal health coverage

Icddr,d's work has fed into policy-making and planning of healthcare service delivery in Bangladesh. The studies of Icddr,d have generated evidence to support policy-making and tools to facilitate the planning of healthcare services. The organization has also provided direct input into policy-making, such as feeding into the Government of Bangladesh's first healthcare financing strategy. Examples of Icddr's achievements include: GIS mapping of healthcare facilities and women's rights.

Non-communicable diseases

Research goals in non-communicable diseases (NCDs)

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.

Icddr,d's achievements in non-communicable disease research

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

2. Checking benchmarking critical areas on Icddr,b

Using the business excellence model, my findings are discussed below:

a) Leadership

Icddr's has strong leadership. They have 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.

b) Strategic planning

Icddr,b has developed a Strategic Plan 2015–2018 that has identified six goals to guide its activities in the short term. These are:

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

c) Customer and market focus

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 Icddr,b work is provided by the six building blocks of health systems identified by the WHO: service delivery; the health workforce; information systems; medical products and financing.

d) Measurement, analysis and knowledge management

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

f) Process management

Icddr,b is a 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; and liaising with the Government.

g) Results

The major results and achievements of Icddr,b include the following:

- Oral Rehydration Solution
- Zinc Treatment for Diarrhoea
- Tetanus 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

Strengths

- Iccdr,d has been established and provided community services for the past 57years. It has rich experience in providing community services and conducting high level research and training.
- Iccdr'd produces vaccines.
- Iccdr,b is known for treating diarrheal cases at Hospital level.

Threats

- The community seeking clinical service, both at the icddr,b Centre in Dhaka and at Matlab research and health service center, are not paying minimal fees. This may affect the sustainability of the service if demand for the service increases in the future.
- The icddr,b does not have financial independence so far. Raising funds to sustain different activities may be challenging in the future.

Recommendation

- Iccdr,b is providing valuable services to the community; but reasonable fees may need to be considered for poor people.
- Iccdr,b needs to maintain the commitment of clinical staff in the Diarrheal Centre
- Iccdr,b needs to advice on government policies through evidence-based research findings.

Conclusion

Iccdr,b is a successful organization with a world class diarrheal disease control centre. I have appreciated the involvement of Iccdr,b in community services, which fill the service gaps. The research, particularly in the health services, is an important component.

Acknowledgement

I would like to thank Prof. John D Clemens, Executive Director of Iccdr,b, for accepting my planned visit. I also thank Dr. Shams El Arifeen, Senior Director and Senior Scientist, for the valuable discussions we made. My thanks go to Dr Twaha Mansurum Haque, the

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On behalf of the International Institute for Primary Health Care in Ethiopia and myself, I would like to thank you all for giving me the opportunity and sharing your experiences.

IV. SUMMARY TABLE

Table comparing four institutes

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

	IPHC-Ethiopia	Jamkhed -India	BRAC-Bangladesh	Icddr,b Bangladesh
Short description of each institute	Established less than 2 years ago, currently in a preparatory phase, the institute is now in the process of attempting to become an independent institute in order to have direct and 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 largest 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 in order of their importance	1st: Training 2nd: Research 3rd: Community services 4th: Conference facilitation	1 st : Community services 2 nd : Training 3 nd : Community participation 4 th : Research	1st: Training 2nd: Community services 3rd: Marketing 4th: Evaluation & Res.	1st: Clinical services 2nd: Rural community services 3rd: Research 4th: Training
Accountability	To the Federal ministry of health, Ethiopia, It is currently in the process of trying to become 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

	IPHC-Ethiopia	Jamkhed -India	BRAC-Bangladesh	Icddr,b Bangladesh
Best practices	<ul style="list-style-type: none"> • Health system structuring by the government • Political commitment to the HEP • Selection criteria of HEWs in the rural community 	<ul style="list-style-type: none"> • Frequent training & Participatory appraisal methods • Role of mobile team <ul style="list-style-type: none"> • Community development work 	<ul style="list-style-type: none"> • Microfinance support • Marketing & accessing different supplies to the community • Its universal engagement 	<ul style="list-style-type: none"> • Unreserved support of clinical services • Uninterrupted research engagement <ul style="list-style-type: none"> • 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 whether than supporting and following the governmental structure	Limited on their catchment population and low-income schemes.

Needed Improvements	<ul style="list-style-type: none"> • Increase commitment of HEWs • Very close follow up of HEWs • Continuing need based trainings • Conducting evaluation studies 	<ul style="list-style-type: none"> • Sustain a revolving fund • Needs more focus towards young age groups attitude • Planning for project sustainability 	<ul style="list-style-type: none"> • Critically evaluate its own working force attitude • Needs to be more engaged in research & support the policy makers and existing structure of the Government 	<ul style="list-style-type: none"> • Needs to work on finding way to achieve financial independency • Work on better means of income generation • Make sure their research outcome influences the policy makers
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Note: Both BRAC and Icdrr,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 submit 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 become a problem. Thus 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 institute.