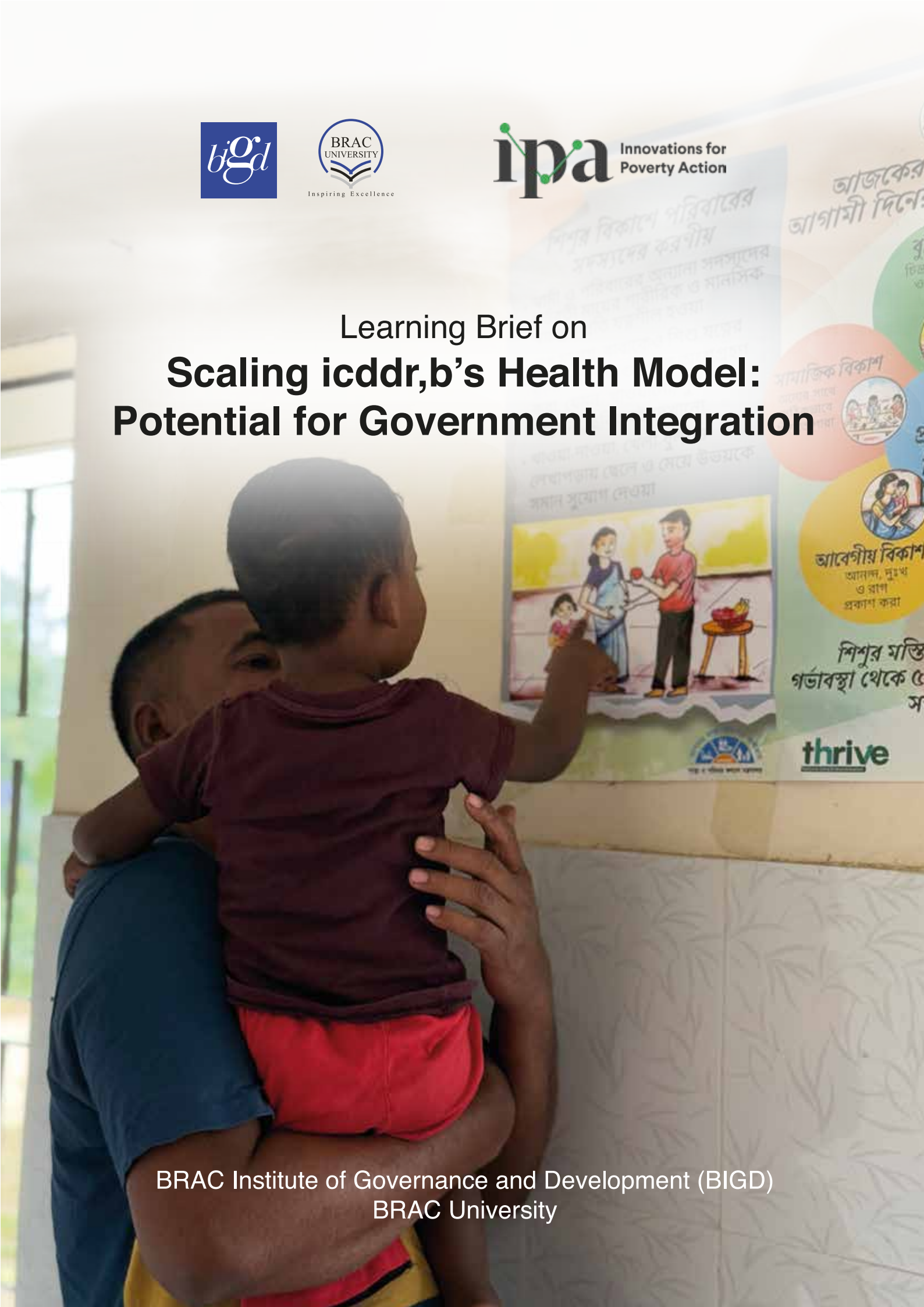
Learning Brief on

Scaling icddr,b's Health Model: Potential for Government Integration



BRAC Institute of Governance and Development (BIGD)
BRAC University

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Context and Background

Integrating ECD into Bangladesh's health system has been a strategic priority, given its profound impact on children's overall well-being. It was first integrated into Bangladesh's National Nutrition Services (NNS) Operational Plan during the 2011–2016 Health, Population, and Nutrition Sector Development Program (HPNSDP). The primary purpose of this integration was to enhance child development outcomes by incorporating ECD components into nutrition-specific and nutrition-sensitive services. This approach aimed to promote protective and responsive caregiving and feeding practices, thereby supporting the physical growth and cognitive development of children aged 0–3 years.

The Government has also been working with NGOs and CSOs to embed ECD in the health system. A notable instance of this partnership is the "Saving Bangladesh's Babies' Brains (SB3)" program, which has been implemented through community clinics within the government's Primary Health Care system. These initiatives aim to enhance parents' childcare knowledge and practices, thereby promoting optimal child development outcomes. The core component of the program is to conduct psychosocial stimulation sessions for parents of children aged 3-36 months. Implemented in government-run community clinics, the programme follows a cascade training model led by icddr,b, with the ultimate goal of government ownership and scale-up.

Scope and Objective

This learning brief explores the sustainability of icddr,b's health model (SB3 project) if adopted by the government. It is based on primary data collected from field visits to eight community clinics in Bramanabaria, Habigonj and Laxmipur through KIIs, which were held with Community Health Care Providers (CHCPs), Health Inspectors (HIs), and Upazila Health & Family Planning Officers (UH&FPOs). Parents attending psychosocial stimulation sessions regularly, frequently, or not at all were also interviewed.

Path to Scale by Government

Our field observations suggest that the model still requires active and substantial support from icddr,b to operate effectively within the health system. This need is driven by two key factors: 1) design factors and 2) system factors. Design factors refer to the structural and programmatic components of the model, while system factors pertain to the existing challenges within the health system that prevent the government from independently implementing the model.

1) Design Factors

- **Training and Capacity**: The cascade training model designed to train community health workers (CHCPs/Has/FWAs) through HIs/AHIs/FPIs was found ineffective due to infrequent sessions and inconsistent quality. Some CHCPs informed that they found icddr,b's sessions to be more engaging and comprehensive than government-led training and reported that HIs usually do not enthusiastically perform training, which leads to inefficient refresher sessions. Icddr,b also confirms that they had to step in to conduct training on behalf of the upper health sector management in many cases. Many CHCPs and HIs reported that the last government training took place in 2019, prompting icddr,b to conduct refresher training in 2024. This highlighted the need for continued external training support. Stakeholders such as UH&FPOs, HIs, and CHCPs themselves claimed that structured and periodic training plan, ideally with continued icddr,b involvement, is essential for long-term success.
- **Parents' Active Involvement**: According to several CHCPs interviewed, parental attendance at psychosocial stimulation sessions has declined since the program's inception. One CHCP noted that while sessions initially attracted around 15 parents, attendance has now dropped to

an average of 4-5 per session. Many CHCPs reported that the play materials provided for child stimulation deteriorate quickly, reducing engagement, and are not appealing to either children or parents. Some parents mentioned that they have better toys at home, making the materials provided less attractive.

Despite these challenges, parents who attend regularly report positive developmental outcomes in their children, including improved cognitive and social skills. However, many mothers struggle to participate due to household responsibilities and a lack of family support. For more retention, some parents suggested offering incentives such as snacks, vitamin supplements, and higher-quality play materials. The sessions can also be tagged with children's immunization dates. Additionally, stronger community sensitization efforts could be implemented to enhance parental engagement and retention in the program.

2) System Factors

- **Motivation of community-level health workers:** The program design envisions CHCPs, HAs, and FWAs conducting parenting sessions with parents. However, due to not receiving their salaries for the past 8–9 months, their motivation and performance have declined. HAs and FWAs are expected to be present at community clinics three days a week but are frequently absent, shifting additional responsibilities onto CHCPs. Moreover, their roles are not full-time, making it unreasonable to expect full-time engagement in these sessions.

  Some CHCPs go the extra mile by providing medicines as an incentive for parents to attend the sessions, demonstrating their dedication while also highlighting systemic shortcomings. Despite their commitment to the program, financial insecurity and a lack of institutional support pose significant threats to its long-term sustainability.

- **Monitoring and Supervision:** The monitoring system in the health sector remains weak, with minimal to no oversight from Upazila Health Officials. CHCPs reported that HIs and UH&FPOs rarely visit clinics or oversee programme implementation. In many areas, icddr,b staff (district coordinator) convince the HIs to conduct the monitoring visits. Sometimes, they do the session monitoring themselves. Some HIs/FPIs engage in private businesses such as setting up their own pharmacies near clinics, which diverts their attention from responsibilities of community health clinics as they provide more of their working hours in their businesses despite being a salaried employee of the government. Furthermore, CHCPs often do not maintain proper documentation of session implementation and progress due to lack of motivation. Establishing a government-led monitoring framework, including oversight committees with child specialists, could enhance accountability and effectiveness, according to the UH&FPO of Brahmanbaria.

- **Infrastructure and Physical Environment**: People typically visit community clinics to receive free medication for common illnesses and seek maternity advice, with consultations lasting a short time. However, the structural design of these clinics does not accommodate longer stays for consultations and treatment, making it even more challenging for adults to attend with infants.

  Therefore, several infrastructure gap issues in community clinics affect session quality and attendance. Many clinics suffer from frequent power outages and rely on electricity from neighboring households, impacting service delivery. Limited space and seating arrangements create overcrowded conditions that discourage parents' participation. Additionally, many clinics lack access to drinking water or have non-functional toilet facilities.

  Some CHCPs reported local leaders stepping in to support infrastructure improvements, such as providing ceiling fans and repairing motors. However, these efforts are insufficient and inefficient. Addressing these infrastructural deficiencies through coordinated efforts between

local government and community stakeholders is necessary for sustained government adoption of this model.

Way Forward

Our field observations indicate that the model still requires active and substantial support from icddr,b to function effectively within the government health system. It is not yet capable of operating independently within the government framework.

To strengthen the model, the government can enhance its design by incorporating more community sensitization efforts to raise awareness of parents about the psychosocial development of children aged 6–36 months. Additionally, it can directly conduct training for community clinic health workers (without involving HIs/APIs/FPIs) in collaboration with icddr, b to ensure its quality. Currently, new community clinic health worker recruits receive training from DGHS, which ranges from 2 to 6 weeks depending on their role. The parenting session training can be integrated into this existing framework. However, for successful implementation, the government must first address the systemic challenges within the primary healthcare system mentioned above.

Scaling up this model requires not only refining its design but also sensitizing policymakers at the government level. Establishing stronger formal and informal relationships with government stakeholders is essential to ensuring the model's long-term sustainability.

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