

**Assessing voice and accountability in
Health, Population and Nutrition Sector
Development Programme, 2011–2016**
Final Report

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Executive summary

The objective of this assignment is to provide input to the HPNSDP Annual Programme Review in September 2013 on opportunities and options to enhance ‘voice and accountability’ (V&A) in the health sector programme. It does this through:

- 1) Mapping current V&A initiatives, including those initiated outside the GoB structures, which build upon the scope of the health sector programme;
- 2) Preparing case studies with analyses of the strengths and limitations of influential V&A initiatives and the circumstances, factors and levers that increase their effectiveness and impact; and
- 3) Identifying feasible and constructive lessons learned and recommendations on V&A of relevance to HPNSDP and to DFID health sector programming in Bangladesh.

The work was undertaken between June and August 2013 through a review of international and national literature, a semi structured set of visits, meetings, and key informant interviews, and an iterative process of report development particularly with DFID Bangladesh health, governance and social development staff.

The range of initiatives studied were:

- The GoB initiative in revitalising Community Clinics throughout the country. This revitalisation explicitly includes structures and arrangements for citizen participation linked to the responsibilities of local government (and particularly the union and upazila council chairmen) in oversight of the health sector.
- In addition, the MOHFW is leading a number of initiatives aimed at strengthening the voice of citizens. These include the Charter of Rights, Women Friendly Hospitals, and LLP.
- The existence of these government initiatives provides the context for other DP-supported and NGO-delivered interventions in this regard. These include:
- Initiatives by NGOs independently seeking to mobilise community voices with health as one of a number of contexts and NGO initiatives in other fields which aim to strengthen governance. These include:
- Initiatives aimed at increasing the information available to individual citizens and organisations so that they are able to interact more effectively with service providers. These include:
- Initiative on the ‘demand side’ to put purchasing power for services directly in the hands of clients. These include
- Initiatives that separate the role of purchaser and provider and make use of a contract as the means of accountability and potential community influence, such as:

Government

GoB has created a credible framework for the exercise of accountability and for hearing citizen voices. This combines the well-established vertical approaches of the MOHFW (sometimes in combination with other ministries) with the roles of local democratic structures (at union and upazila levels), as well incorporating a space for NGOs and CBOs to work with communities and help them raise their voices.

GoB recognises that the on-ground reality of V&A does not match its vision and that the considerable out-of-pocket expenditure levels place a large part of the health sector outside any formal accountability framework. It is willing to work with DPs to enhance the reality of V&A, particularly where this can be seen to enhance the functional performance of health services and improve the health status of the population.

Political context

Bangladesh has a functioning democratic system. It is, however, marked by elements of violence and intimidation as well as strong elements of financial influence and patronage. Nevertheless, this is by no means unique to Bangladesh and clearly lies outside the scope of this analysis beyond the necessity of an understanding of this context. Given these realities, the key questions are around the potential for continuity of approach in reality even where the superstructure and presentation may change.

There are a number of reasons to expect that, as the country gears up for a general election in 2013 and thus the possibility of a change in regime, substantial continuity can nevertheless be achieved and can be made more rather than less likely through legitimate selective interventions. First, elections, and the period following an election, provide an opportunity for policy lobbying and for briefing of the incoming government. Second, in practice any government will not wish to break things that are working but rather to paint them in their own colours – this provides an opportunity for public servants and others to demonstrate what is working.

At a more general level, there are countervailing institutions that will limit the tendency towards discontinuity. These include the burgeoning media and the weight of civil society and NGOs. These are complemented by the realisation that Bangladesh is part of a global community where internal debate is inevitably accompanied by external judgements, influences, and guidance.

Thus, both in the immediate context and over time any consideration of how V&A can be strengthened in the health sector needs to give consideration to how the political parties, professional groups, media, and civil society organisations can become better informed about health policy and systems issues.

The role of MPs has been developing, with increasing emphasis being given to local powers through both spending and chairmanship of key bodies, including HMCs. It is not clear that in respect of health that the Parliamentary Standing Committee can exercise an informed scrutiny of the executive. For example, through making use of the independent expertise of say Health Watch in its hearings.

Enabling environment

In recent years economic development and specific aspects of industrialisation and marketable agriculture production have been putting more cash into the hands of the relatively poor in Bangladesh. This includes, but is not limited to, the huge development of the garment industry. On the demand side this provides more opportunities for direct interaction in the health services market, and on the supply side creates circumstances where the self organisation of the citizenry is less dependent on elite interventions.

Related to the above is the question of short and long routes of accountability and opportunities for voice. It is indeed interesting that while government has created and operates long routes – from community to union to upazila to district to division and national level – it is also experimenting with the short route of text messages direct to the MOHFW about client experiences and doctors being

seen to be present at the hospital through Skype. With at least 50% of rural populations having access to a mobile phone this creates quite different opportunities for the exercise of voice.

More generally, while the progress of deconcentration of authority down the long routes continues to be limited there has been a strengthening of general decentralisation through the structures of local government. In particular, union and upazila chairmen not only have a responsibility for oversight of 13 programmes including health but also have discretionary spending powers that can be applied to support for health care delivery. While the sums of money may not be large there is the power of 'money at the margin' and the sense for citizens that simple problems can be solved at a level that is accessible to them. Somewhat in contrast, however, there is still a sense that too many issues have to be referred up the line by MOHFW officials, which is discouraging for them and for communities.

Clearly there are opportunities for capacity strengthening of these local political leaders as well as MPs so that they become better informed monitors and arbitrators on health issues. It may be that national think tanks and other national apex organisations need to orientate their work as much towards improving the quality of information available to local political figures as to exercising influence at the national level.

As the media continues to mature in Bangladesh so will its role in providing platforms for citizen voice. There are clear opportunities for helping health specialising journalists to become better informed of best practices and international experience of various topics.

The international evidence and our observations to date indicate that there is a key role for third parties in facilitating both community organisations and for facilitating the relationships with health providers and government. This works best when it supports a process where all involved see benefits in engagement rather than promoting adversarial relationships. It is perhaps obvious that if the poorest in the community are to gain a voice it will only be with the assistance of others.

Therefore, the question should not be about some absolute notion of sustainability where poor communities are self-sufficient in these roles but rather about the resources needed over time (i.e. more at the beginning and less eventually), so that communities can organise themselves in governance, resource mobilisation, and advocacy.

Demand- and supply-side interventions are not mutually exclusive alternatives. It is instead a matter of the best balance and of ensuring that supply can respond to demand. The main approach to demand-side intervention at present is the use of vouchers for reproductive health. The initial evidence is promising in terms of take-up of services and the creation of useful incentives to the supply side.

The relationship between demand and side may not necessarily be mediated through contracts. However, it is contracts that can provide the basis for enhanced accountability and opportunities to express voice collectively. The main examples of contracts currently are in the Urban Health Programme and these are providing limited scope for engaging citizens through local government.

Health system

The public health system in Bangladesh has been able to achieve good results in rural and peri-urban areas with low levels of expenditure. There is a concern, however, that this success is due to being able to target the 'low hanging fruit' and thus that these gains mask inequities. There is also concern that the challenges of health care for the poor in the rapidly growing urban areas are not being met effectively.

The traditional power relationship between doctor and patient remains very much skewed towards the medical profession, making it difficult for many doctors to appreciate the contribution to improved health outcomes that can be made by patients individually and collectively and making it a difficult arena for citizens to express their concerns with confidence. It is also important to recognise that secondary and tertiary health care involves highly technical delivery systems and therefore that it is intrinsically difficult for providers and consumers to interact with mutual respect.

While GoB is committed to the principle of LLP, funding specifically dedicated to this purpose is very limited and has tended to produce tokenistic adherence to the process. It is probably seen by health professionals as a poor use of time since it is difficult to associate planning in isolation with practical improvements in health service delivery. Following the example of block grants to union level through the LGSP we believe there is scope for a supplementary or parallel scheme with funds earmarked for PHC.

The MOHFW is well designed as a technical ministry and has shown great success in this respect. Right down to the community level the staff of the Ministry are respected for their technical and clinical expertise. However, the Ministry is neither designed nor has a cultural inclination towards processes of community development. In this respect, communities look to elected representatives and the organs of local government as the local decision makers and problem solvers. This raises important questions about the best roles and relationships for the delivery of a primary care-based health system.

Therefore, not only is the CC initiative important because of its widespread and government-led characteristics but also because it creates an opportunity for easily observed and welcomed mutual benefits rather than antagonistic relationships. However, the politicisation of the programme creates potential problems.

Roles and relationships in community mobilisation

In a democratic society it is axiomatic that through representational processes citizens are able to influence the way in which public resources are used and private resources are regulated. While this is a matter of rights as well as efficiency, it is still proper to consider the cost of how this is achieved and the impact on functioning (for example, of health services).

Where the general held assumption – confirmed by reality – is that government will act in the general and impartial interest of citizens and the specific interests of the vulnerable, the executive branch can be expected to make arrangements for the hearing of voices and the legislative branch will act as a check on such arrangements as part of its role of holding the executive accountable.

Certainly until recently this has not been the general assumption about government in general and health services in particular. This is due to a general distrust of government, exercise of patronage by elected representatives, and a medical profession perceived to be driven by individual and collective self-interest. In these circumstances it has been seen as necessary and legitimate for independent third parties to fill substantially the democratic deficit as well as service deficiencies.

This way of doing business has a cost. Our estimate is that five years of support to a CCMG and CSGs would cost about US\$ 5,000 so scaling up to an additional 13,000 CCs would cost about US\$ 65 million over a five-year period.

Assuming that these same resources could have been deployed directly to health care, this also implies benefits foregone in terms of health services and health status. It thus follows that what these resources are used for is important. Personal appropriation or denial to patients of

pharmaceuticals is a matter for criminal action; coming to work on time and staying for the required period is a contractual obligation; paying for posting, turning a blind eye to non-attendance, or procuring a clean audit is corruption. These matters are efficiently fixed by good government and strong management, not by citizen committee meetings.

On the other hand, making judgements about the quality of services, supporting good management, assisting service delivery, and promoting good health-seeking behaviours are both functionally contributive and provide real opportunity to exercise a voice.

It is also the case that the poorest and most vulnerable are the least well placed to have their voices heard and hold providers to account. The case for third parties is therefore undisputed. Instead, the more interesting and important questions are whether, to what extent, and at what pace there is a paradigm shift underway with a move towards supporting good government and strengthened management rather than looking to substitute for it.

Recommendations to government

- To maintain a vigorous approach to completing the programme of establishing a comprehensive network of CCs and associated CCMGs and CSGs.
- To work closely with MOLG so as to continue strengthening the links between CCMGs, union parishads, and upazila councils.
- To undertake operational research and implement effective measures for using new technologies to provide a route for community organisations to provide structured feedback about quality and utilisation of services.
- To review the operation of HMCs and adopt a more rigorous approach to monitoring their effectiveness and taking remedial measures when performance is not effective.
- To strengthen the GEVA-TG through the inclusion of line directors involved in major initiatives in V&A.
- To consider how the views of women users can be heard and incorporated into the design of voucher schemes and monitoring of implementation recommendations to DFID and DPs.

Recommendations to DFID and DPs

- To establish through the pooled funds a Community Health Development Fund to provide funding for third-party support to CCMGs and CSGs; block grants to provide for small discretionary expenditure based on LLP; and capacity strengthening of local government chairmen and councillors.
- To provide support through the pooled funds for a scheme to revitalise and strengthen schemes for hospital accountability to communities served. This should include technical assistance and capacity strengthening for the operation of HMCs and small grants to recognised hospital user forums and similar bodies.
- To provide financial support to think tank-style organisations proposing and then implementing schemes for providing expert knowledge support to community-level organisations and facilitating the exchange of information and good practices between such organisations.

- To work with the LD-MIS to explore and fund promising innovations in the use of new technologies to strengthen citizen voices.
- To explore options for improving the expert knowledge of health specialising journalists so that they are better informed of best practices and international experience

Recommendations to NGOs and civil society organisations

- Based on the learning from experiences so far, design low-cost but effective means of providing support to citizen groups.
- To explore means of collaboration, information exchange, and sharing of good practices in citizen participation in health.

List of abbreviations

ANC	Ante-Natal Care
AusAID	Australian Association for International Development
BRAC	Bangladesh Rural Advancement Committee
CA	Client Association
CBO	Community-Based Organisation
CC	Community Clinic
CCMG	Community Clinic Management Group
CCR	Citizen's Charter of Rights
CDI	Community-Directed Intervention
CG	Community Group
CHCP	Community Health Care Provider
CmSS	Community Support System
CSG	Community Support Group
COPE	Client Oriented Provider Efficient
DDFP	Deputy Director-Family Planning
DFID	Department for International Development
DP	Development Partner
DSF	Demand Side Financing
EPI	Expanded Programme for Immunisation
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GEVA-TG	Gender Equity Voice and Accountability Task Group
GoB	Government of Bangladesh
HEART	Health and Education Advice and Resource Team
HI	Health Inspector
HMC	Hospital Management Committee
HPNSDP	Health, Population and Nutrition Sector Development Programme
HPSP	Health and Population Sector Programme
JICA	Japan International Cooperation Agency
LGSP	Local Governance Strengthening Project
LLP	Local Level Plan
MJF	Manusher Jonno Foundation
MNCH	Maternal, Neonatal and Child Health
MNHI	Maternal and Neonatal Health Initiative
MOHFW	Ministry of Health and Family Welfare
MOLG	Ministry of Local Government

MP	Member of Parliament
NGO	Non-Government Organisation
NHA	National Health Account
NP	Naripokkho
OP	Operational Plan
OPM	Oxford Policy Management
PHC	Primary Health Care
SBA	Skilled Birth Attendant
SIDA	Swedish International Development Cooperation Agency
SMPP	Safe Motherhood Promotion Project
SWAp	Sector Wide Approach
TIB	Transparency International Bangladesh
UHC	Upazila Health Complex
UHFPO	Upazila Health and Family Planning Officer
UHFWC	Upazila Health and Family Welfare Centre
UNICEF	United Nations Children's Fund
V&A	Voice and Accountability
WHO	World Health Organisation

1 Introduction

1.1 Background

The Ministry of Health and Family Welfare (MOHFW) of the Government of Bangladesh (GoB) is currently implementing its third health sector programme, known as the Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011–2016. The programme, supported by a host of Development Partners (DPs) including DFID, aims to *“improve access to and utilization of essential health, population and nutrition services, particularly by the poor.”*

The principle of strengthening the effectiveness and accountability of service provision through ‘participation’ has been introduced in the national health sector programmes over the years but reviews to date have shown very slow progress in this area. These were initially driven by the aim of reaching countrywide coverage for major national initiatives, including family planning, immunisation, and control of diarrhoeal diseases, through inviting participation rather than strengthening accountability.

In the early 1980s the Directorate General of Family Planning at the MOHFW engaged the local councils formally for popularising family planning throughout the country. A union level (below sub-district) ‘Standing Committee for Family Planning’ was formed, with the wife of the Union Chairman being nominated as the lead. Several initiatives for increasing the quality and utilisation of care have also provided scope for participation of service users, e.g. ‘client oriented provider efficient’ (COPE) methodology, establishing issue-based local champions groups, interventions for improving planning such as Local Level Plans (LLPs), and the ‘client charter of rights’.

The first Sector Wide Approach (SWAp) – the 1998 to 2003 Health and Population Sector Programme (HPSP) – envisioned major reforms that formally created scope for people’s participation and raising voice in an attempt to establish accountability at the local level at a scale. 13,500 community clinics (CCs) were to be established at the lowest tier of service delivery on land donated by the people. The CCs aimed to increase access to health services while their management system allowed greater participation and voice of the general people in the programme in the form of Community Clinic Management Groups (CCMGs), which included members of the local government (union council) as well as women and poor representatives as mandatory members.

The idea was that empowered CCMGs will help the local MOHFW in delivering the services efficiently as well as ensuring that a mechanism of accountability is established at the local level. This was built on earlier pilot experience of mobilising communities and building their capacity to oversee service provision and increase accountability of front-line workers at the grassroots level.

HPNSDP’s predecessor – the Health, Nutrition and Population Sector Programme (HNPSP) 2003–2011, the second SWAp – emphasised some of the initial reforms. However, with the change of government in 2001 and accompanying change of policy, much of this initiative could not be implemented. Only a few of the CCs remained open, and largely through local and non-government organisation (NGO) support.

Platforms for people’s participation and to hear from users of public services have also been opened in the ‘Health Users’ Fora’, the ‘District Users Fora’, the union-level ‘Family Planning Committee’, the Parliamentary Standing Committee on Health, LLP interventions, in various health facility surveys and reviews of the sector programmes, etc. A Citizen’s Charter of Rights was formulated and later revised in 2007.

HPNSDP 2011–2016 reiterates the previous policy emphasis on providing a platform for communities to voice their issues and hold public servants accountable. The current government created the Revitalisation of Community Health Care Initiative Project Bangladesh 2009–2014, with special support from the Prime Minister’s Office. Currently it has been incorporated within the scope

of the HPNSDP. Guidelines for formation of the Community Clinic Management Group (CCMG) and its mandate and a training manual have been developed and funds have been mobilised to strengthen the capacity of the CCMGs in partnerships with NGOs.

The HNPSP and the HPNSDP consistently acknowledge the need for strengthening on gender and equity issues, and expanding its collaboration with civil society organisations (non-state sector) to achieve its objectives. In HNPSP, initiatives to strengthen Gender, Equity, Voice and Accountability formed a separate line of activities so as to emphasise and track these. However, not much was achieved as they remained outside the purview of the main service delivery channels.

The design of HPNSDP includes forming a Gender NGOs, Stakeholder Participation and Partnership Unit (GNSPU) and developing a strategy for public–private partnership. In recognition of the need to address Gender, Equity, Voice and Accountability throughout the implementation, HPNSDP has established a Gender, Equity, Voice and Accountability Task Group (GEVA-TG), co-chaired by the Joint Chief of the Health Economics Unit and by SIDA. Represented DPs include AusAID, DFID, GIZ, the Netherlands, SIDA, UNICEF and WHO.

In 2003, DFID commissioned a study to document some examples of effective citizen participation in influencing and improving the quality of health service delivery in Bangladesh. This assignment is both an update and an extension of that initiative, which produced a collection of case studies intended to inform citizen participation as a means of improving the responsiveness of services to user needs and public accountability.

This assignment has been commissioned by DFID, in liaison with the MOHFW, GoB and DPs, through the PEAKS, HNE facility and undertaken by the Health and Education Advice and Resource Team (HEART). The team is led by Mike Naylor, Principal Consultant Health at Oxford Policy Management (OPM) and HEART Director.

1.2 Objectives of the assignment

The objective of this assignment is to provide input to the HPNSDP Annual Programme Review in September 2013 on opportunities and options to enhance ‘voice and accountability’ (V&A) in the health sector programme. It does this through:

- 4) Mapping current V&A initiatives, including those initiated outside the GoB structures, which build upon the scope of the health sector programme;
- 5) Preparing case studies with analyses of the strengths and limitations of influential V&A initiatives and the circumstances, factors and levers that increase their effectiveness and impact; and
- 6) Identifying feasible and constructive lessons learned and recommendations on V&A of relevance to HPNSDP and to DFID health sector programming in Bangladesh.

The MOHFW and DPs contributing to HPNSDP will be the recipients of the findings of this assessment. It will feed into the technical assistance provided through DFID Bangladesh funding to HPNSDP. The results will be shared with GoB policy-makers, DPs and others – initially through the HPNSDP Annual Performance Review in September 2013.

The full terms of reference are provided as Annex A

1.2.1 Outline methodology

The first phase of the work was undertaken between 12 June and 9 July 2013 under the following guidance:

Undertake an initial scan of examples of existing initiatives in V&A in relation to the health sector programme – by government and/or civil society – and identify a sample of these for further detail review and analysis.

Selection should focus on identifying relatively successful initiatives that can offer lessons learned in terms of both design and implementation, and that may have the potential to be duplicated and/or scaled up in future. A preliminary classification of initiatives of interest would include:

- *Approaches that directly **empower individuals** to take greater control over their lives and to hold their government to account;*
- *Approaches that **strengthen community action** to effectively engage in health service provision collectively mobilise and demand better services; and*
- *Approaches that **support accountable and responsive governance** through enhanced capacity of health service providers.*

Prior to the start of the Phase 1 field work a literature review of international and Bangladesh experience in V&A was commissioned from the HEART Core Services, and this is attached as Annex B.

Annex C provides a listing of other reference documents identified during the assignment.

Following the first phase of the work an initial report was prepared and shared with DFID and this helped determine priorities for investigation in the second phase. The second phase of work continued from mid-July to this report in mid-August 2013.

Field work has included:

Key informant interviews with:

- MOHFW officials (Primary Health Care (PHC), CCs, Management Information System / Planning);
- DFID Health, Social Development, and Governance Advisors;
- Japan International Cooperation Agency (JICA) Senior Health Advisor;
- CARE;
- Manusher Jonno Foundation (MJF);
- PLAN Bangladesh;
- UNICEF;
- World Bank; and
- Asian Development Bank.

Meetings with:

- Public health practitioners of Bangladesh;
- Bangladesh Health Watch;
- SIDA Reality Check;

- ICCDR, B Team;
- GEVA-TG – DPs (convened by SIDA);
- Health DPs;
- Group of health journalists;
- GK; and
- Naripokkho (NP).

Visits to:

- Safe Motherhood Promotion Project (SMPP) / CARE Activities in Narsingdi;
- MJF Activities in Narsingdi;
- SMPP / CARE Activities in Satkhira;
- Transparency International Bangladesh (TIB) activities in Mymensingh and Madhupur;
- PLAN Activities in Gazipur; and
- Maternal and Neonatal Health Initiative (MNHI) / UNICEF Activities in Jamalpur.

Annex D provides a complete list of persons met.

2 Conceptual framework

2.1 General approach

The methodology behind this work was intended to be iterative. The hypothesis, problem and structural analysis and approach to recommendations are based on the knowledge and evidence held at the time of writing. All these elements have been tested and updated as additional information has been made available.

The general hypothesis behind this work is that increasing the voice of citizens as well as the accountability of government services will result in both improved (more efficient) service delivery from government (duty bearers) and enable people to realise their rights.

The GoB has made great strides over the last 40 years in terms of improving the health outcomes of a great majority of its citizens. This has been delivered at relatively low input costs (roughly around US\$ 4 per head in rural areas) through a highly centralised and central state directed system.

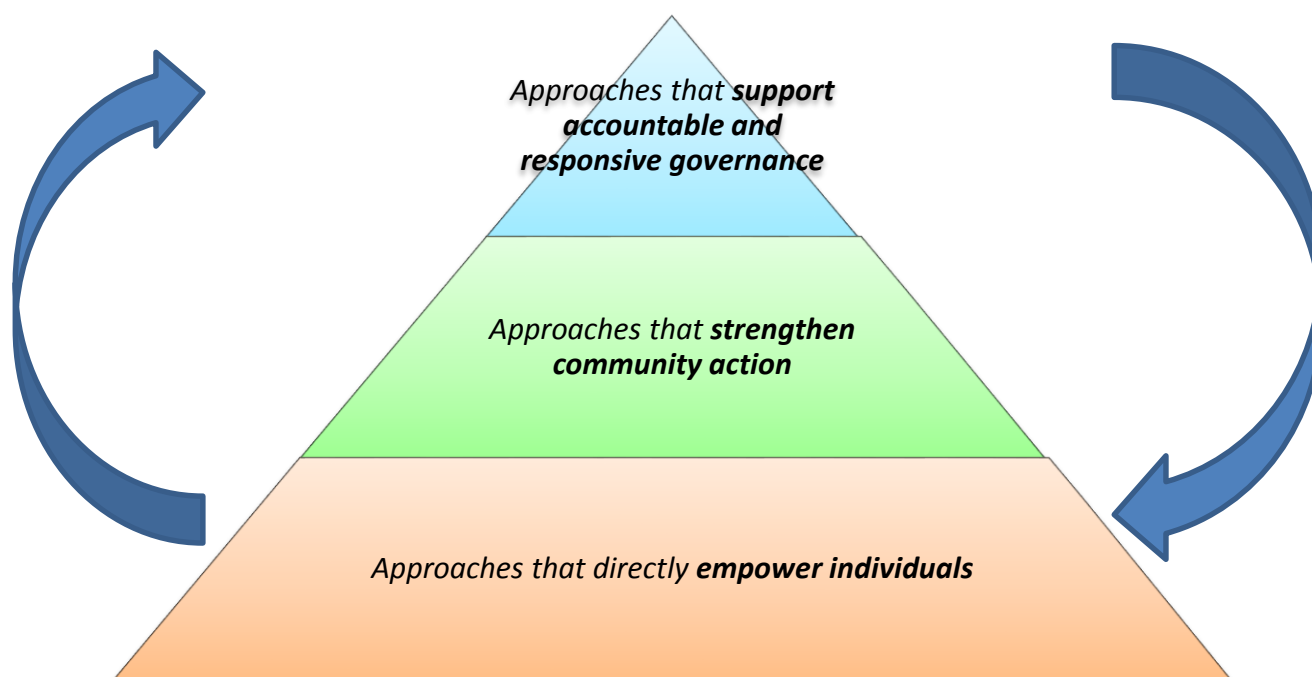
However, due to structural weaknesses in terms of how services are delivered, as well as changes in the social structure of Bangladesh (notably increased urbanisation) and macroeconomic progress (e.g. extensive use of mobile networks, immigrant workers, etc.), the efficiency gains that are possible mainly through only technical improvements may be limited and additional gains may be available through deeper involvement of citizens.

The problem is analysed in the context of:

- The **political economy** of Bangladesh;
- The **general enabling environment** of Bangladesh, considering the economic, social, legal and political framework within which citizens, government and other change agents operate; and
- The **health systems** framework and directions.

The desired **outcome** of this work is that recommendations are developed which will demonstrate the impact that increasing V&A will have in the health sector in Bangladesh in order to feed into the annual review of the Health Sector SWAp programme in September 2013. The **impact** would be that health outcomes in Bangladesh continue to improve at an increased efficiency rate in Bangladesh.

It is the team's contention that a methodology that views the classification of initiatives as being part of a hierarchically virtuous V&A circle is most appropriate, as the diagram below shows:



The approach includes analysis of vertical (long and short) and horizontal accountability mechanisms.

The official governance structures through which citizens can exercise voice around the health sector differ in Bangladesh – notably between rural and urban areas. The typology below has been drawn up in relation to governance structures for rural citizens.

It is critical that any interventions around the vertical and horizontal accountability chains are referenced in regard to an understanding of the **political economy** of the health sector in Bangladesh, as well as posited within the general **accountability enabling environment** in Bangladesh. Political economy may require in-depth analysis and consultation throughout the study. The enabling environment can broadly be constructed with reference to the social, legal, regulatory and political issues that frame the health sector – all from an accountability perspective.

3 Scanning of initiatives

3.1 The MOHFW perspective

3.1.1 Accountability arrangements

In regard to public expenditure, GoB believes it has created a strong framework. The structure of its strategic and annual planning provides for specific allocation of responsibilities to line directors and measurement of results through indicators. In relation to the HPNSDP, indicators at the level of the operational plans have been formulated to facilitate clearer and greater accountability on the part of the respective line directors. This is supported by stronger management and personnel information systems. Delegation and associated monitoring is clearly articulated tier-by-tier down the system. There is attention to quality of services and the use of operational research is seen to prompt improvements in services.

It is accepted that these strong systems are not always matched by compliance, necessary skilled human resources and strength of supervision, and that continuing attention is required. In particular, there is recognition that some of the unhelpful behaviours of health workers and supervisors have to be tackled through a mutual commitment to professionalism to be achieved through:

- Enhanced rights of workers to an accurate job descriptions and skills development;
- Analysis of job descriptions of the various cadres in the context of population growth, capacity, etc.;
- Advocacy with the professional bodies;
- Measuring performance and acknowledging good performance; and
- Promoting nurse leadership and introducing midwives.

There is concern that 64% of health expenditures are out of pocket (National Health Account (NHA) 1997–2007) and not subject to significant accountability or citizen voice. It is recognised that this needs correction over time through an increase in the share of government participation and through organisation of out-of-pocket spending into collective purchasing (e.g. health insurance), so that the limited accountability that can be achieved through individual purchasing can be amplified through collective purchasing.

3.1.2 Voice

Similarly, GoB has seen the importance of prompting citizen voices and responding to them. This is to be understood in the context of broader societal changes. These include the continuation and extension of free female education, increasing formal employment opportunities for women as well as general economic development, significant improvement in communication systems countrywide using IT, commendable improvements in water sanitation through people's participation (i.e. Community Led Total Sanitation), a facilitating environment for strong NGO participation in services and advocacy, and a progressively strengthened media.

It is accepted that the success of such programmes as the expanded programme for immunisation (EPI), use of oral saline to address diarrhoea, family planning, etc. have been based on emphasising the mobilisation of communities rather than engagement in decision making.

However, this is changing and there is now a greater emphasis on providing better information and responding to questions from the public.

The government has a vision on the supply side of a respected client who feels happy with the service provider. This has been expressed in a number of ways, including the Charter of Rights, CCMGs and Community Support Groups (CSGs), Women Friendly Hospitals, seeking client views through suggestion boxes, direct texting of concerns, client satisfaction surveys as part of facility surveys, encouragement to service managers to assess client satisfaction, and hospital management boards chaired by the local Member of Parliament (MP). GoB recognises that the implementation of these schemes is currently patchy in terms of impact and requires strengthening.

GoB has further recognised the importance of attention to the demand as well as the supply side. In 53 sub-districts it is seeking to increase access to reproductive health services for poor mothers through use of vouchers. In these sub-districts ante-natal care (ANC) is reported as increasing from 50% to 80%. While DP funded through the pool at present, government intends to begin assuming financial responsibility from 2016.

3.1.3 Community clinics

It is self-evident that the initiative to revitalise CCs is the most significant government-led initiative involving citizens in health care. It has strong 'centre of government' advocacy and support and active collaboration between the MOHFW and other ministries, particularly including the Ministry of Local Government (MOLG). It has actively engaged DP support including USAID and the JICA and involved a range of NGOs in organisational development activity with CCMGs and CSGs.

As at March 2013, 12,248 CCs were in operation and 13,240 Community Health Care Providers (CHCPs) had been appointed. These include 224 clinics providing normal delivery and referral services and this strategy is therefore strongly linked to further reduction of maternal and infant mortality through training of skilled birth attendants (SBAs) and improving referral services.

The formal descriptions of the role of the citizenry are focused on governance and support to management and on practical support to the operation of clinics and services. Advocacy to higher levels is linked to LLP, but it is recognised that in practice the role extends beyond that (particularly given the deliberate engagement of local councillors and chairpersons).

3,500 clinics have internet-enabled laptop computers and this is being rapidly extended to all clinics.

The national leadership recognises that intensive NGO-style support to all CCMGs and CSGs will be difficult (although they would welcome further such participation). A more limited form of support is provided through GAVI Health Systems Strengthening in 13 districts. Moreover, a number of clinics and support structures are operating where there has been no support beyond the initial training.

3.1.4 Innovative approaches

The team has been impressed with the innovative approaches in the use of new technologies which strengthen and potentially strengthen V&A. These include the provision of a tablet computer to every community health worker and a laptop computer in every CC.

Other applications of new technologies include the text messaging suggestion / complaint line; tracking staff location and activity; aspects of disease surveillance; tracking key indicators for maternal and child health; basic electronic patient records; teleconferencing; e-learning; and health promotion material.

The anticipated organisational impact of the application of these approaches include bringing diverse public and non-public providers together for fortnightly updates of information; information and performance profiles that are available simultaneously at all levels; rapid response to problems; and analysis of common and recurrent problems.

It is apparent that opportunities for more direct tapping of citizen views can be enabled through these technologies.

3.2 Scanning of initiatives

The terms of reference require the scanning of existing initiatives and the identification of those that show promise and from which lessons can be drawn. We identified the following initiatives as deserving of more detailed study:

1. The most significant single initiative is that of the GoB in revitalising CCs throughout the country. This revitalisation explicitly includes structures and arrangements for citizen participation linked to the responsibilities of local government (and particularly the union and upazila council chairmen) in oversight of the health sector.
2. In addition, the MOHFW is leading a number of initiatives aimed at strengthening the voice of citizens. These include the Charter of Rights, Women Friendly Hospitals, and LLP.
3. The existence of these government initiatives provides the context for other DP-supported and NGO-delivered interventions in this regard. These include:
 - CARE support to CCMGs and CSGs funded by JICA in:
 - Locations where it had previously been supporting CSGs (e.g. Narsingdi); and
 - New locations as part of the revitalisation programme (e.g. Sathkira).
 - GAVI Health Systems Strengthening Programme in 11 districts, to be extended to a further 19, which includes support to CCs and CSGs as well as renewed attention to LLP.
 - Maternal and Newborn Health Initiative implemented jointly with the government by UNFPA, UNICEF and WHO in Jamalpur, Thakurgaon, Narail and Moulvibazar in the first phase (supported by DFID, the EC and CIDA) and another seven districts in the second phase supported by CIDA.
 - PLAN Bangladesh Projects in Gazipur and Northern Areas.
4. Initiatives by NGOs independently seeking to mobilise community voices with health as one of a number of contexts and NGO initiatives in other fields which aim to strengthen governance. These include:
 - MJF Project in Narsingdi;
 - TIB in Mymensingh and other districts; and

- World Bank-supported Local Governance Strengthening Project (LGSP).
- 5. Initiatives aimed at increasing the information available to individual citizens and organisations so that they are able to interact more effectively with service providers. These include:
 - Bangladesh Health Watch; and
 - Reality Check study series supported by SIDA.
- 6. Initiative on the ‘demand side’ to put purchasing power for services directly in the hands of clients. These include
 - Maternity vouchers; and
 - Health insurance feasibility project supported by KfW.
- 7. Initiatives that separate the role of purchaser and provider and make use of a contract as the means of accountability and potential community influence, such as:
 - Urban Primary Health Care Programme.

3.3 Case studies

Based on the scanning of initiatives, field trips were undertaken to six interventions and these are described below.

3.3.1 CARE in Narsingdi

Description of intervention

SMPP initiated its interventions in July 2006 in Narsingdi District supported by JICA. JICA invited CARE Bangladesh to be another implementation partner for community mobilisation activity.

In Narsingdi, CARE developed a Community Support System (CmSS) at the union level to develop better linkages with Union Council and Upazila Health Complex (UHC) and raise common voice. They provided training to CmSS members, facilitated their meetings and monitored their performance. The SMPP categorised CmSS into three levels in terms of maturity: satisfactory, moderate and weak. The categorical criteria are: leadership; conceptual and technical skill; documentation; monthly meeting and participatory monitoring; resource mobilisation; accountability; and linkage and communication. Weak CmSSs received additional training.

In 2011, the CmSSs in Narsingdi started extending their support to CCs.¹ CARE provided training to the Community Group (CG) and CSG members. They facilitate the meetings of CG and CSG and work to identify the problems and probable solutions for better functioning of the CCs. The CG’s major tasks (in order of priority) include: i) advice and guidance for Community Health Care Provider on who to give drugs, how to behave properly, monitoring the availability of drugs, etc.; and ii) Raising the community’s voice to the Union Council Chairman. The problems identified in the CG/CSG meeting are raised in the Union Council Meeting.

¹ The present government gave top priority to revitalising the CCs through a development project called ‘Revitalisation of Community Health Care Initiative in Bangladesh (Community Clinic project)’. Under the project, almost 13,000 CCs have become functional.

At upazila level, an upazila coordination meeting is arranged every month. Representatives of the CG, Union Council and the Upazila Health and Family Planning Officer (UHFPO) attend the meeting. Problems and potential solutions related to CC are discussed at this meeting. If problems cannot be solved at the union level, these are raised in the Upazila Council Meeting. CARE helps the CG and CSG members in developing evidence-based case studies, which they can present in council meetings to create awareness among the Union Council Chairman, Upazila Council Chairman and other stakeholders.

Observations of the team

CARE followed a systematic process to mobilise the community to develop CmSS and later CG/CSG. They adopted a three-stage model to form these groups: 1) Develop individual capacity; 2) Form groups of individuals through identifying natural leaders and spokepeople from the community; and 3) Create a platform for them to raise their voice at union level (Union Council) and upazila level (Upazila Council) coordination meetings.

The process contributed in developing self-confidence among people in discussing and analysing issues, identifying a problem, visualising disparities, understanding their entitlements, identifying their duty bearers, articulating problems, developing a plan as a team to address their problems, and communicating this properly to the appropriate forum/platform. A good example is the recent transfer of a Family Welfare Visitor (FWV) in Ichapur Union, which the CSG members considered as their greatest success. As a result of their consistent persuasion, the post of a FWV was filled recently, which had previously remained vacant for two years.

It was evident that once the CG/CSG starts functioning, they can come up with some innovative ideas to run the CC. One such example in Ichapur Union is the 'patient record book', which the CG has prepared and printed for each household. Each household has to bring the record book when visiting the CC. The CHCP keeps a record of the amount of medicine given to the patients in the book, which helps to monitor how frequently the household is visiting the CC and receiving medicine at what quantity.

The CSG members in Musapur Union have also prepared a list of telephone numbers of all elite and influential persons in the union, including the UHFPO, Union Council Chairman and Health Inspector (HI). They can now directly call them to inform them about a lack of availability of medicine at the CC or the unavailability of the CHCP meaning the CC has not opened on time. CG members also refer patients to the UHFPO, and can contact him by phone in the event of an emergency, such as the need for a C-section.

In Ramnagar CC, the CG members have decided to give medicine to a client for a maximum of two days. Following this rule has improved drug distribution and there is no shortage of drugs in this CC.

A linkage has been developed with the Union Council through the CCP. Two members in the Union Council are also members of the CG, of which the Union Parishod Chairman is the Secretary of the CG. His active role has enhanced coordination between health and local government. The Union Council Chairman donated BDT 1,000. With this money, CSG members bought and distributed 100 small tokens (earthen pots for saving coins) to 100 pregnant mothers. Previously, he gave two tons of rice to two CSGs. CSGs sold the rice and used the money for the CC. The Union Council Chairman also donated a water filter to Ramnagar CC. This creates a linkage between the CG and Union Council.

If the CC needs any resources, the CG/CSG contacts the Union Council Chairman. In the event of patient-related problems, they seek help from the HI. Moreover, the HI tried to solve the problems with the electricity in CCs through a discussion with the Power Development Board. However, there remains resource constraint for the Chairman and HI. For example, the HI has only been able to ensure electricity is supplied to seven CCs out of 54 CCs in Narsingdi. Also, the Union Council Chairman gets a budget against line items, where virement between line items is not possible. He

cannot provide money to the CC even if he wishes so, although he can provide support to the CC from his 'Food for work' project.

It should be noted that a number of CG/CSG members in Narsingdi had prior experience of working with a SMPP project. As a result, they have been able to facilitate the meeting with little support from CARE, can maintain records of meetings, and can also raise their concerns regarding the CC at council meetings.

Key lessons

- Two to three years external support will often be necessary in order that CCMGs and CSGs become self sustaining.
- The 11 NGOs and other projects working with the CCs are currently supporting approximately 25% of CGs/CSGs. Greater efforts from the government and partners is therefore required to make the CGs/CSGs functional.
- NGOs can contribute in policy advocacy at the central level or by developing modules for training of CG members.
- It is crucial to develop linkages and networks with local government to achieve the objective.
- Project activities solely focusing on V&A in the health system create tensions among health care providers. V&A needs to be integrated into projects aiming at overall health system strengthening.
- Even if the ruling party changes in the upcoming election, the CC project and community mobilisation approach associated with the functioning of CCs have already been integrated into the SWAp under the Operational Plan for Community-Based Health Care, and are therefore likely to continue.

3.3.2 CARE in Satkhira

Description of the intervention

CARE, with the technical support of JICA, started mobilising the CG and CSG in Tala Upazila, Satkhira in 2012. Training was provided to CG and CSG members. Currently, a CARE representative moderates the CG meeting and advises on what should be discussed in the meeting, what should be written in the resolution, and how to do follow up on previous meetings' resolutions.

CARE provides the CG and CSG with relevant information and data including on potential sources of funding and any changes in rules and regulations. CARE informed the CSG members that the CSG Member Secretary has been included as a member of the Union Development Coordination Committee, and explained that this will create an opportunity for the Member Secretary to discuss health-related issues in that forum. The information helps them to motivate local people, and to communicate with the UP Chairman and other relevant persons.

Observations of the team

The CG and CSG have created a better referral linkage between the CC and UHC. The patients they refer get special attention and preference at the UHC. Moreover, due to the monitoring activities of the CG and CSG, the CC remains open from 9 am to 3 pm six days a week.

Fund raising has been considered as a major activity of the CG and CSG. The CG encourages local people to donate funds to the CC, and they themselves also pay BDT 10 per month. The CG has used the accumulated money to buy chairs for CC. CSG members also pay BDT 10 per month and intend to use the saved money to pay the transportation costs of patients transferring to the UHC.

CG members also encourage the Union Council to allocate funds to the CC. The UP Chairman has upgraded the road used to access the CC, allocated two fans, given a water filter, and provided curtains at the CC. The CG also celebrates special days with the UP Council, such as the 'Safe Motherhood Day' celebrations where the UP Chairman gave pregnant women BDT 50 and a coin box.

The UHC now arranges C-sections for twice a week due to the pressure from the CSG. This was not available before. Due to their persuasion, the Union Council Chairman hired a cleaner for the UHC and has allocated funds to pay for her salary. CG and CSG members are creating awareness among the local people about what services are available at the CC, that ANC is necessary during pregnancy, and that VIA tests should be provided to women after 30 years of age.

It appeared that the classroom-based training and guidelines provided for the CG members by the government were not very helpful, and many issues discussed during the training were not clear to them. They need hands-on training about their roles and responsibilities, what to do, and how to do it. CARE gives CG members hands-on training in this vein and on what people's roles and responsibilities are.

It was evident that CG members needed lots of support from CARE to facilitate their meeting, but the CSG Member Secretary could moderate the CSG meeting without the support of CARE. The CG is recently formed and all the members are new to this kind of activities, while, in contrast, the Member Secretary was a former member of a local women's group, and had prior experience in social mobilisation and conducting courtyard meetings.

CG members had some innovative ideas to improve service provision, such as testing the blood groups of pregnant women and some potential blood donors, and keeping the records to be referred to in an emergency. They planned to arrange a blood test day at the community with the support of the UHC and planned to encourage people to donate blood.

CG and CSG at Tala Upazila is functioning well compared to many other committees. For example it was reported that the 'Union Disaster Management Committee has no voice. They do meetings but do not know how to follow up'. However, sometimes CSG members need legal support from other organisations, such as the police department, but the police have provided no support in stopping dowries or early marriage. This lack of support has created problem for CSG members on several occasions.

Key lessons

- The leadership of the Union Council Chairman is crucial for the success of CGs. The Union Council Chairman attends CG meetings every two months.
- For capacity development and sustainability, the CG and CSG need at least two years of support.
- The CSG is creating demand for health care; however, there remain supply-side problems. People now want safe delivery as they are now more aware that there is a shortage of SBAs in the community and C-sections are not available every day.
- The UP Chairman allocates funds to the CC, but no fund is provided to the CSG to facilitate their activities.

3.3.3 MJF in Narsingdi

Description of intervention

The MJF has broad interests in good governance and rights which it pursues through national policy advocacy (including a National Committee for Health Rights) and in field activities in association with local NGOs. In health their work is mainly at the union level and below, forming groups independent of government structures. However, they seek to work collaboratively with service providers and local governments using a variety of tools and supporting the development of skills in participation. These tools support government systems and include a participatory citizens charter, community score card, and suggestion boxes.

A key strategy for MJF is the identification of influential local champions who can form a bridge between the poor and marginalised and government and service providers. They recognise a key role for upazila and union chairmen and seek to support them in their supervisory role. They estimate that it takes three years to establish viable local structures.

One Client Association (CA) has been formed in each union with 21 members. First, local influential individuals are identified. Courtyard meetings are then arranged that are open to the local population and a CA is formed on a participatory / democratic basis. The CA at upazila level involves two representatives from each union-level CA.

The major task of the CA is identified as identifying and helping to solve problems associated with service delivery at public facilities. CA members discuss issues with the UHFPO and Union Council Chairman. For example, they recently requested the Union Council Chairman to fix the tube well in CC. For bigger financial requirements they rely on the UHFPO to discuss their issues with the MP and Civil Surgeon.

Creating awareness among the people and demand creation are also seen as important functions. The CA arranges health camps and other events to disseminate information on what health services are available and where, the rights of people in accessing health care, HIV/AIDS, and the adverse effects of child labour and early marriage.

MJF places a lot of emphasis on the use of tools as the basis for bringing the key players together. Community people, civil society members, the Deputy Director-Family Planning (DDFP), UHFPO and CA members have developed the citizen charter together. The citizen charter outlines what services are available at UHFWC. Now, patients do not come with their broken hand to UHFWC as they know that services to help them are not available there. The charter also mentions the opening hours of UHFWC. If it does not open on time, people can make a call to the DDFP and inform him of this.

The score card has also been developed in a participatory way. Every month, providers and CA members sit together to revise the score card. Through the card, they can track the changes in the perceived quality of care of providers and patients over time. They also discuss probable solutions that would improve quality of care; they send their recommendations to the upazila level.

Although the MJF approach is of independent organisations, they have been able to integrate with government-mandated structures such as the CCMG and CSG. CA members attend meetings and the resolutions of these meetings are also sent to the CA, which discusses the issues they raise in their meetings.

MJF provides training to CCMG members. After training, the CG chairman is aware of when the CHCP needs to open the CC, how much medicine the CC gets, and how frequently the medicine is received, as well as of other issues.

Observations of the team

Elite participation is deliberately fostered but genuine attempts are nevertheless being made to include the poor and women. A key feature of the CA, and a perceived contributor to its success, is the involvement of political leaders from all the political parties. The CA membership deliberately includes key political figures like the Union Council Chairman, which encourages informal as well as formal processes to be used as ways of getting things done.

UHFPO readily established a partnership with the CA including allocation of a room for meetings within the complex. He tries to use them as allies. The CA seems to be ready to tackle difficult issues like attendance of doctors. This was seen as supportive by the UHFPO rather than as diminishing his authority. Moreover, CA pressure has led to the provision of diagnostic services in the UHC that were previously only available in private facilities. The Residential Medical Officer stated that MJF has created a bridge between provider and recipients through CA. He said, 'I am now encouraged to provide quality care. Demand has been created. People are now coming in UHC'.

MJF in concert with elite champions help CAs to find their way through the influencing and decision-making systems. For example, MJF helped the CA to meet with the local MP and helps to get media attention for CA work. An MJF representative informed the CCMG Chairman of how to contact the Union Council to get access to funds available under block grants to the Union Council. The CCMG Chairman said 'he (MJF representative) knows everything, knows people. His presence makes the CG confident'.

The feeling that everyone wins is an important aspect of the approach. The greatest success was described as developing coordination between health care providers and clients. Moreover, people now think that public health care facilities are their property and the reputation of the CA members in the community has gone up, as has utilisation of services and respect for providers at UHFWC.

The CCMG Chairman has given 10 chairs to the CC, and has changed the door. He has also talked to the Rural Electricity Board about the possibility of getting electricity at the CC and to the Union Council about repairing a road adjacent to the CC.

Key lessons

- Ways have been found to utilise the skills and influence of the elite while still making a space for the voices of the poor and women.
- The importance of creating opportunities for mutual benefit among stakeholders has been highlighted.
- Careful construction of the membership of community organisations is needed.
- Being seen to solve problems and make a difference is useful in getting and keeping the support of communities.
- Third parties can be used as route finders through complex systems and relationships.
- Providers are seeing the advantages to be gained through allowing space for advocacy and criticism.
- Well-designed tools can be used as a means for creating opportunities for participation.

3.3.4 PLAN in Gazipur

Description of intervention

PLAN is working in Gazipur in one upazila and in the northern areas. They have a mandate for support to about 1,000 CCMGs and are active with 700. The intervention in Gazipur is still in the early days and is working with six CCs, to subsequently be expanded to 47.

PLAN applies a uniform process called 'Child Centered Community Development Approach' (CCDA) to encourage community mobilisation. This is a general process which then leads-on to specific interventions including in health. Their approach is to get the community to discuss and analyse their situation and then to inject ideas about improving their situation particularly with regards to basic services and governance.

In health they have identified the opportunity offered by the government-mandated CCMGs. They deploy the CCDA process to encourage and raise the skills of women and younger people in expressing their opinions in meetings dominated by men.

They provide the standard two-day training in accordance with government guidelines and then provide additional training in gender, child protection, leadership, facility management, and the conducting of good participatory meetings (minutes, follow-up of action, etc.).

Groups are encouraged to raise their own funds and to use these to solve small problems, support poorer mothers, etc. As well as support, some CCMGs are also active in management; some need to be prompted to become so.

PLAN is active in identifying political and bureaucratic figures who can be decision makers on resources. It also works with partner organisations who in turn recruit community mobilisers who are paid an honorarium of BDT 1,800 per month and in turn assist the work of the CCMGs. One partner staff member works with 10 mobilisers who work with two CCMGs.

The process of getting to maturity is considered to take about three years and depends on how supportive the rest of the environment is. In this respect, they also do capacity-building work with local government and co-ordinating structures.

PLAN also undertakes capacity-building activities with union chairmen and with the various coordination and standing committees at the local levels.

Observations of the team

The team made a visit to a very good example of the potential of CCs. From registers it seems that attendees number around 40 per day on average, with an average of two attendances per annum per person.

The CCMG saw their role in terms of practical support and some governance responsibilities. They made people new to the catchment area aware of the clinic and its services. They were self sustaining through a monthly fee and had been able to raise funds for an aya and a night guard. Furthermore, the CCMG managed a system of exemptions for the ultra poor.

It seemed to us that the health assistant was not fully occupied and the CC could certainly cope with higher workload with the same staffing.

The local NGO – DSK – employs community health promoters who are trained by PLAN in CCDA. We observed a health promotion session on nutrition during pregnancy. It did not seem

that there was much awareness among the women attending this group about the role and activities of the CCMG. However, the Community Health Promoter said that she would take the problems raised by such a group to the CCMG.

PLAN had initiated a quarterly meeting at the upazila level and helped to take issues to that level. However, the general view was that more progress could be made by solving problems at ground level rather than through advocacy to higher levels. The HI saw part of her role as that of linking up to higher levels.

Unusually, the CC also includes a laboratory seeing about 10 patients per day.

The CC includes a safe delivery facility staffed by three midwives and providing a normal deliver and referral service. The midwives are employed by DSK and clearly at present this would not be a nationally replicable service. It seemed that at least 70% of deliveries from the area were managed by these midwives and the facility looked pleasant and professional.

Key lessons

- Where good value and accessible services can be developed, communities can find the means to provide support to those services and subsidise the poorest.
- NGOs must be careful in supporting enhanced services that will not be sustainable in the longer term.
- CCMGs and CSGs perceive more benefit in concentrating on matters within their control than in exercising influence at higher levels.
- Third parties are effective in synthesising and carrying messages to higher levels.
- Revitalisation of CCs should be strongly linked to other key health initiatives so as to maintain credibility within the health care provider community, and thus avoiding being perceived as a strongly political initiative.

3.3.5 TIB in Mymensingh and Modhupur

Description of intervention

The core interests of TIB are in good governance and the reduction of corruption. This involves them in national research and advocacy but also local activities, valued for their own sake but also providing ground-level experience to inform their work. They seek to build capacity to improve governance within state institutions.

TIB believes that, while the relationship with government is bound to have its tensions, they are able to have real impact.

The modality of local work is the formation of Committees of Concerned Citizens (CCCs). These CCCs consist of concerned citizens in the locality but are supported by TIB-employed staff. A CCC will focus on a single institution with the aim of creating an 'Island of Good Governance'. It will also have an associated youth organisation known as 'YES'. There is a deliberate strategy of seeking to involve local elite individuals who can facilitate their work.

When an institution has been ‘chosen’ for intervention, TIB then supports the CCC with key methodologies and tools (e.g. citizen report cards, organising face-the-public meetings, use of complaint boxes, use of the citizen charter, ‘open budget’, etc.).

They have the formal support of government for these activities but of greater importance is the involvement of well-respected local people. They also see it as important to remove the fear among government officials that name-and-shame tactics will be used. They recognise the importance of seeking relationships with elected politicians and have been involved in work around the ‘proper role’ of an MP trying to influence a gradual shift away from patronage relationships.

In Mymensingh the focal institution in health since 2003 has been the Mymensingh Medical College (a tertiary-level hospital). In Modhupur, the focal institution has been the 50-bed UHC since 2001.

Observations of the team

The team made a visit to Mymensingh Medical College along with members of TIB and the CCC. This is a 1,000-bed tertiary hospital with high in-patient and out-patient volumes. The hospital has fairly frequent changes of leadership and it was apparent that the CCC felt the need to re-establish a relationship with the Executive Director.

The CCC has an information desk in the hospital and a group of volunteers. They aim to have a quarterly meeting with the hospital leadership and put forward suggestions.

The Hospital Director seemed reasonably familiar with the work of TIB and the CCC and referred to some improvements, although he did not ascribe these directly to the work of the CCC. He referred to improvements in doctor attendance and to less medicine having to be bought outside. However, he also referred to the considerable obstacles to real control over the workforce due to external factors.

The overall impression was of little real advance in tackling systemic problems of corruption and a sense of lack of authority to do so in spite of good intentions.

The team attended a well-attended meeting of the CCC and YES members. In spite of their own evidence there was a reluctance to consider that after 10 years efforts a continuation of efforts at the Medical College might not be the most fruitful approach. A much more positive report was given of work with a school.

While the need for alliances was accepted it was felt that these would not be productive with elected officials because of the frequent cases of corruption.

The team also made a visit to Modhupur UHC. It was felt that third-party intervention in tackling corruption at the upazila level was relatively easier than at the district level. The power structure at the upazila level is less complex, where the UHFPO and Upazila Chairman enjoy equal socio-political position in the locality; they are easily accessible by TIB and CCC members.

It was reported that CCC and YES members contributed to enhancing the cleanliness of the UHC, introduced the culture of queuing at the patient waiting room and, most importantly, ensured the availability of the doctors at UHC during working hours. It was claimed by the Upazila Council Chairman and other CCC members that the project activities are sustainable if TIB support was phased out now. Despite this enabling environment, the lack of sufficient authority on the part of the UHFPO in managing human resources at UHC seemed to be an impediment to curbing corruption at UHC.

TIB is clearly an effective campaigning organisation but will always experience difficulty in negotiating the complex and ambiguous relationships that are prevalent in Bangladesh.

Key lessons

- For understandable reasons impact on a complex, large, tertiary institution is likely to be limited and therefore less likely to be a demonstrable exemplar of better governance. However, there is likely to be more positive impacts from such initiatives at the upazila level.
- The support of the local government is critical for success.
- Forging alliances can be a messy and compromising process and it may be difficult for anti-corruption campaigning organisations to engage in such processes.
- On the other hand, the youth will be attracted to such an organisation and this is advantageous.
- The approach of TIB in documenting and publishing reports against corruption creates tension among stakeholders and makes them reluctant to collaborate.

3.3.6 MNHI in Jamalpur

Description of intervention

The specific interventions in the areas of V&A are part of the broader programme jointly of government and the UN 'Accelerating Progress towards Maternal and Neonatal Mortality and Morbidity Reduction' project (also known as MNHI). Phase 1, 2007–2012, covers four districts including Jamalpur. Outputs 1 and 2 strengthen LLP and the availability of services. Output 3 is concerned with increasing awareness and demand for services and Output 4 with increased equity, participation and accountability.

This is a district-wide joint initiative engaging NGOs (Unnayan Sangha for Output 3 and Wave Foundation for Output 4) as the immediate agents of community mobilisation and organisation. Work is undertaken in all seven upazilas including 267 CCs as well as the district hospital level. While the focus is on maternal and child health, interventions around V&A have general impact.

The mode of community mobilisation is the CmSS, which uses the CC as the focal point for activities. Forty paid supervisors each guide and supervise up to 48 Community Health Volunteers (CHVs), with six of these associated with each CC.

The NGO provides capacity-building support to the CCMG and helps to forge links with local government. Capacity-building support is also provided to local government (Union Parishad), while annual plans and community maps are produced in line with general guidance.

Output 4 work is focused at the upazila and district hospital level. The key methodologies are public hearings, Health Service User Forum (HSUF) meetings, an information desk in the hospital, suggestion box, and press conferences. The focal point of all of this is the HSUF, largely consisting of local influential people. The forum links the citizen voices expressed collectively and individually to formal government bodies such as the hospital management committee (HMC) and maternal, neonatal and child health (MNCH) meeting.

Observations of the team

The initiative is currently focused on the district hospital and CCs within one upazila. The Civil Surgeon seemed well aware of the nature of the initiatives, which may be reflective of the design as a partnership between the Ministry and the UN agencies.

If what we observed was typical, a functioning maternal and newborn health system is in place, with the district hospital dealing with the more difficult cases (50% plus C-section rate reported and four small babies in the neonatal intensive care unit) and upgraded CCs attracting over 50% of normal deliveries. Five CCs per upazila at seven upazilas (i.e. 35 in total) have been upgraded for normal deliveries. The six-month training of female health assistants and family welfare assistants as SBAs is being undertaken and in addition training is being given to 'private' SBAs (CSBAs).

At the village level we observed a typical pregnancy-planning session being undertaken by a Community Health Volunteer (such volunteers being a particular characteristic of this initiative). These volunteers took an obvious pride in their work and the status that it gave them within the community.

The CCMG visited – while consisting of a majority of men – nevertheless had very strong female leadership within it. Its membership was clearly an elite group within the community. The focus of the group has been on the 'support' function and a number of typical problems relating to electricity and water supply have been solved by members of the group either directly or by gaining favourable decisions from the local government.

The Union Council has provided BDT 20,000 for each of the three CCs including the one that we visited. The Upazila Council has donated wheat, which is sold to raise cash and then this is used to enhance the facility.

Attendance at the clinic (taking random days within the register) is impressive with a daily average in the order of 50 clients, suggesting an overall visit to population ratio in excess of 2.5.

The local NGO (Unaayan Sanghaa) was described as being an initiator in relation to the CC, providing training and raising issues for consideration. There is one Unaayan Sanghaa supervisor per eight CCs.

The key intervention at the hospital level is the HSUF. This engages in a number of activities but the main function is described in terms of gathering users' issues, prioritising them, and determining the best route for pursuing them. Notably this includes direct access at the meeting to the HMC (chaired by the MP). Where problems are not solvable locally they use the mechanism of a 'press conference' to try to get attention at higher levels. The Civil Surgeon (CS) saw the HSUF as helpful to his work.

It was reported to us that the activities of the HSUF also encouraged a more active functioning of the HMC.

This positive perception was somewhat reduced when it transpired that, while continuing some activities, the HSUF had actually not met for six months prior to the special meeting for our visit. The reason given for this was the lapsing of the contract between UNICEF and the supporting NGO (WAVE). This provoked some lively discussion in the meeting and a resolution to continue with small subscriptions and support from the CS for the meeting room. The view of the President was that the NGO had not given sufficient attention to sustainability. It also transpired that the NGO was caught by surprise by the ending of the contract.

It is an elite group, notably including a number of journalists.

We observed the suggestion box but with its placement on the outside wall and in the absence of pens and paper it was hard to understand how it worked in practice. The Advice Desk was in operation.

Key lessons

- It is important to be able to recognise when a CG is capable of being sustained independently of external support and how to concentrate limited resources on those with greatest need.
- Sustainability mechanisms need to be built in from the beginning of an intervention.
- There is a value to government and health officials being integrated in an initiative but this carries a danger of them over-defining the boundaries of action.
- Improving citizens' understanding of more general issues of V&A in the context of a well-defined health care priority programme brings many benefits.

3.3.7 Synthesis of lessons from case studies

- CCMGs, CSGs, and hospital related user forums need up to three years third-party support to become sustainable. Sustainability plans need to be implemented from the outset of support and use of graduation indicators to track progress is recommended.
- MOHFW and MOLG need a joint plan to make all CCMGs and CSGs effective at least at a minimal level. This plan should then be supported by DPs and NGOs.
- Based on an initial analysis of information from NGOs our estimate of the cost of third-party support to a CC is about US\$ 1,200 per annum (not including any share of overheads).
- Local government elected officials – including women councillors – are vital to the success of V&A initiatives at the community level.
- Tensions and fears about the motivation behind V&A initiatives can be reduced when such initiatives are clearly integrated with service delivery improvement programmes. Executed in this way, they also make better sense to all stakeholders.
- Cross-party consensus on the future of community-based health services would assist forward planning of services and reduce the sense of politicisation of the revitalisation programme.
- There are many good examples of flexible use of discretionary funds and these examples should be shared.
- Now that there is a growing body of organised demand for better services, the MOHFW and MOLG need to consider how this can be matched with enhanced supply-side capability with community-level support (e.g. for transportation).
- Elite participation in community structures fits with the cultural reality but third parties need to be active in promoting the voices of the general citizenry.

- Seeing that problems are tackled and solved is the key to maintaining citizen participation and their own material support. However, NGOs should be careful not to support unsustainable service delivery improvements.
- Third parties have a key role as ‘route finders’ through complex systems and relationships.
- There are many examples of good tools for participations and these should be synthesised and shared with all groups.

3.4 Associated activities

3.4.1 Urban experience

The Asian Development Bank has provided longstanding support to urban PHC, working with local government, and using a Public–Private Partnership model with contracts with NGO providers. They work with the 11 city corporations and four of the municipalities. There is a national-level Project Management Unit within the MOLG and a Project Implementation Unit in each city corporation, these being the contract administrators.

The accountability mechanism is of course the contract and this includes a requirement to provide free care to the poorest in the population. Councillors are involved in the poverty assessment. Citizen participation is indirect and expected to be expressed through the Ward Councillor. He or she is expected to hold a supervisory meeting with the provider NGO once per month.

In addition, two committees are functioning under the UPHCP to raise citizen voices – the User Forum (UF) and the Ward Advisory Committee (WAC). The UF aims to involve a broad spectrum of users including the very poor and is arranged by the NGO running the clinic (our informant being PSKP).

The WAC is established under the guidance of the UPHCP and City Corporation, is chaired by the Ward Commissioner and has more elite membership from the local community. The focus of the discussions is on service quality and access and action tends to be limited to what can be done by the provider NGO.

Formal co-ordinating committees above this level are not functioning and this limits the ability to carry issues to higher levels in local and national government.

3.4.2 Think tanks

Independent expertise brought together in a respected think tank-style organisation can provide a useful counterweight to government and private-sector health care organisations. These include Health Watch, which prepares a major thematic report every year on major health policy areas. The key target audience for these reports are the senior officials of the MOHFW but the findings and ideas of these reports create wider interest.

The ‘Reality Check’ reports can be seen in this same context of offering to government and other stakeholders an alternative or independent perspective on critical health problems.

Organisations such as TIB and MJF also synthesise their experience and seek to influence government policy.

While these are important initiatives, there is a danger – particularly within the political culture of Bangladesh – that rather than reports and comments being welcomed by the government of the day as constructive contributions to the policy dialogue that they are seen as providing unwelcome ammunition to the opposition or producing negative attitudes among DPs.

3.4.3 The Local Government Support Programme

For seven years, and in two phases, the World Bank has been providing support to the Local Government Support Programme. Support is focused on union parishads with the main intervention being the funding of block grants that can be used on a discretionary basis (including health) and are subject to a process of ‘ward-level meetings’ and ‘open budget meetings’. The programme is limited by the size of the block grants and a process that tends to favour small infrastructure projects and equal shares rather than a more strategic approach.

The project has also supported the development of a ‘short route’ voice mechanism through the ‘16256’ Help line for information and questions.

3.4.4 NP initiatives with HMCs

NP was established in 1983 focusing on women’s health and reproductive health activities in order to reduce maternal mortality. NP aims to ensure accountability at various levels. At the **central level**, NP is trying to make the Parliamentary Health Standing Committee functional. They work with 16 community-based organisations (CBOs) at local level. Currently, they are working in five districts, 14 upazilas, 64 unions and 32 villages in Barisal Division. The initiative has been operational since 2001.

At the **district level**, NP works to strengthen the HMC to enhance the accountability and transparency of hospitals. However, the HMCs are not active in many places despite having journalists, doctors, women and local NGOs as members. At the district level, NP has also created ‘alliances’ with their own CBOs (16) and other local NGOs to create pressure on the hospital authorities.

At **upazila** level, NP has activated seven HMCs out of 14. At the **union level**, NP works with 64 unions to strengthen the Education, Health and Family Planning Standing Committee. This is one of the 13 committees at union level. NP collects data from the UHC and hospitals, and publishes it in a local newspaper. Furthermore, NP meets the local press club once every quarter.

Seven out of 14 HMCs at upazila level are functional and they meet regularly. If the MP cannot attend the meeting, he nominates the vice-president to conduct the meeting. The HMCs have contributed to improving the cleanliness in hospitals and monitoring hospital activities.

The major challenges they face are:

- If an MP is from opposition, they are often reluctant to join the HMC meeting.
- A change in government leads to changes in many things associated with the previous government. For example, the HMC was known as the ‘Hospital Advisory Committee’ under another political regime.
- The lack of a financial incentive for the committee discourages MPs from joining the meeting.

- The Upazila Council Chairman is the Vice Chairman of the HMC. However, in many areas, he has a troubled relationship with the MP, which negatively affects project activities.
- Staff turnover is a challenge. NP needs to build relations once again with new staff.

The critical factors for success are seen by NP as being:

- A good relationship between MP and UP Chairman.
- Regular communication between NP and the MP to keep him engaged.
- Building trusting relationships with hospital authorities.
- A minimum of two years being taken in order to make a committee functional by NP.
- Approach not being 'fault finding' but rather 'fact finding'.

The problems they see with the operation of HMCs are:

- Committees are not authorised to transfer or punish someone.
- There is a lack of resources for committees.
- It is hard for CS or UHFPO to entertain the MP and his followers.
- MPs are not committed enough. In many cases, they discuss many irrelevant political issues in the HMCs meetings.
- There is inadequate monitoring.

3.4.5 Role of the media

The team met with a small group of journalists with a particular interest in health issues. The focus of much reporting is on corruption in the health sector and disappointment was expressed about the response of DPs as well as government. Their sense was that the MOHFW was not being held accountable around issues of corruption and that doctors are not held properly to account by the Ministry.

Journalists see a limited role for themselves in relation to community mobilisation – they report rather than organise. However, there are examples of good reporting leading to action by communities against corrupt facilities. Rather than print or web-based media, it is probably easier for TV channels to facilitate debate on health issues. Health is not an 'attractive' issue for newspapers and their readership. That said there are frequent reports on the inside pages about achievements as well as problems in the health sector.

During the discussion, participants informed the team that, according to a recent piece of research, health is ranked as the 7th most interesting topic among readers. As a result, it is difficult for health reporters to publish their articles on the front page of a newspaper. Moreover, it is difficult for readers to understand health issues, such as health insurance, universal health coverage, etc.

The journalists stated that health draws little attention from policy-makers at every level. Health policy is never debated at Parliament and policy-makers are not aware of many health-related issues. For a journalist, making headlines on health policy is a challenge. Indeed, when health policy is being formulated, even the opposition party shows little interest. CBOs were out of the

process, and ultimately there was no debate on the policy. At the district level, the MP does not discuss health issues at public meetings. MPs have lots of work; their first interest is politics and how it is directly related to party people, and as such they do not prioritise health.

The journalists further commented that both of the political parties are the same: they do not prioritise health. For example, the National Nutritional Project was closed without discussion. Participants also stated that the health policy is basically driven by DPs.

In India, the Medical Association publishes a list of quacks online. However, the Medical Association in Bangladesh, although powerful, does not undertake this type of task in the public interest. Nevertheless, Bangladesh TV, Bangladesh Radio and mobile phones are widely used even in rural areas. Fundamentally though, despite the data being available, they are not yet analysed.

3.4.6 Demand side – Maternity vouchers

The MOHFW is piloting a maternal health voucher scheme in 44 sub-districts around the country under its HNPSP. The programme aims at increasing the use of qualified birth attendants and removing the financial barrier for safe delivery of child.

There are several Demand Side Financing (DSF) committees at different levels. At the national level there are:

- The National DSF Steering Committee;
- The DSF Implementation Committee; and
- The DSF Technical sub-committee.

At district level there is the district designation body, at sub-district level there is the upazila committee and at union level there is the Union DSF Committee. Every committee has its own terms of reference. However, a recent study suggests that the functioning of these committees is not always in line with the original terms of reference. For example, the Union DSF Committee does not have regular meetings except the one organised annually by the DSF organisers where there is an honorarium for participation. It was found that many of them are unaware of their roles and responsibilities. It was also found that some of them even do not know the eligibility criteria for women to be included in the DSF programme. They do not keep a record of the beneficiaries and nor do they always know about the benefit package for mothers.

The recent evaluation also revealed that the mothers do not clearly know about the benefits of the DSF. They just receive a card (voucher book) from the health assistant (or FWA) and are not properly educated about the benefits of the voucher scheme. It was also found that the mothers only received BDT 2,000. They did not receive any money for transportation.

Although providers consider DSF as a very good programme for poor mothers in Bangladesh, they argued that the increased number of obstetric patients in the target hospitals due to DSF is entailing additional pressure and an increased workload. This has resulted in increased service volume with unchanged quality of care. The HR situation has not improved for DSF. The programme simply failed to attract the necessary technical staff, such as obstetricians and anaesthetists to work in the target rural facilities.

In the absence of well-functioning committees, and non-response from the supply side, these issues put serious constraints in raising V&A through the DSF.

4 Synthesis and conclusions

GoB has created a credible framework for the exercise of accountability and for hearing citizen voices. This combines the well-established vertical approaches of the MOHFW (sometimes in combination with other ministries) with the roles of local democratic structures (at union and upazila levels), as well incorporating a space for NGOs and CBOs to work with communities and help them raise their voices.

GoB recognises that the on-ground reality of V&A does not match its vision and that the considerable out-of-pocket expenditure levels place a large part of the health sector outside any formal accountability framework. It is willing to work with DPs to enhance the reality of V&A, particularly where this can be seen to enhance the functional performance of health services and improve the health status of the population.

4.1 Political context

Bangladesh has a functioning democratic system. It is, however, marked by elements of violence and intimidation as well as strong elements of financial influence and patronage. Nevertheless, this is by no means unique to Bangladesh and clearly lies outside the scope of this analysis beyond the necessity of an understanding of this context. Given these realities, the key questions are around the potential for continuity of approach in reality even where the superstructure and presentation may change.

There are a number of reasons to expect that, as the country gears up for a general election in 2013 and thus the possibility of a change in regime, substantial continuity can nevertheless be achieved and can be made more rather than less likely through legitimate selective interventions. First, elections, and the period following an election, provide an opportunity for policy lobbying and for briefing of the incoming government. Second, in practice any government will not wish to break things that are working but rather to paint them in their own colours – this provides an opportunity for public servants and others to demonstrate what is working.

At a more general level, there are countervailing institutions that will limit the tendency towards discontinuity. These include the burgeoning media and the weight of civil society and NGOs. These are complemented by the realisation that Bangladesh is part of a global community where internal debate is inevitably accompanied by external judgements, influences, and guidance.

Thus, both in the immediate context and over time any consideration of how V&A can be strengthened in the health sector needs to give consideration to how the political parties, professional groups, media, and civil society organisations can become better informed about health policy and systems issues.

The role of MPs has been developing, with increasing emphasis being given to local powers through both spending and chairmanship of key bodies, including HMCs. It is not clear that in respect of health that the Parliamentary Standing Committee can exercise an informed scrutiny of the executive. For example, through making use of the independent expertise of say Health Watch in its hearings.

4.2 Enabling environment

In recent years economic development and specific aspects of industrialisation and marketable agriculture production have been putting more cash into the hands of the relatively poor in Bangladesh. This includes, but is not limited to, the huge development of the garment industry. On

the demand side this provides more opportunities for direct interaction in the health services market, and on the supply side creates circumstances where the self organisation of the citizenry is less dependent on elite interventions.

Related to the above is the question of short and long routes of accountability and opportunities for voice. It is indeed interesting that while government has created and operates long routes – from community to union to upazila to district to division and national level – it is also experimenting with the short route of text messages direct to the MOHFW about client experiences and doctors being seen to be present at the hospital through Skype. With at least 50% of rural populations having access to a mobile phone this creates quite different opportunities for the exercise of voice.

More generally, while the progress of deconcentration of authority down the long routes continues to be limited there has been a strengthening of general decentralisation through the structures of local government. In particular, union and upazila chairmen not only have a responsibility for oversight of 13 programmes including health but also have discretionary spending powers that can be applied to support for health care delivery. While the sums of money may not be large there is the power of ‘money at the margin’ and the sense for citizens that simple problems can be solved at a level that is accessible to them. Somewhat in contrast, however, there is still a sense that too many issues have to be referred up the line by MOHFW officials, which is discouraging for them and for communities.

Clearly there are opportunities for capacity strengthening of these local political leaders as well as MPs so that they become better informed monitors and arbitrators on health issues. It may be that national think tanks and other national apex organisations need to orientate their work as much towards improving the quality of information available to local political figures as to exercising influence at the national level.

As the media continues to mature in Bangladesh so will its role in providing platforms for citizen voice. There are clear opportunities for helping health specialising journalists to become better informed of best practices and international experience of various topics.

The international evidence and our observations to date indicate that there is a key role for third parties in facilitating both community organisations and for facilitating the relationships with health providers and government. This works best when it supports a process where all involved see benefits in engagement rather than promoting adversarial relationships. It is perhaps obvious that if the poorest in the community are to gain a voice it will only be with the assistance of others.

Therefore, the question should not be about some absolute notion of sustainability where poor communities are self-sufficient in these roles but rather about the resources needed over time (i.e. more at the beginning and less eventually), so that communities can organise themselves in governance, resource mobilisation, and advocacy.

Demand- and supply-side interventions are not mutually exclusive alternatives. It is instead a matter of the best balance and of ensuring that supply can respond to demand. The main approach to demand-side intervention at present is the use of vouchers for reproductive health. The initial evidence is promising in terms of take-up of services and the creation of useful incentives to the supply side.

The relationship between demand and side may not necessarily be mediated through contracts. However, it is contracts that can provide the basis for enhanced accountability and opportunities to express voice collectively. The main examples of contracts currently are in the Urban Health Programme and these are providing limited scope for engaging citizens through local government.

4.3 Health system

The public health system in Bangladesh has been able to achieve good results in rural and peri-urban areas with low levels of expenditure. There is a concern, however, that this success is due to being able to target the 'low hanging fruit' and thus that these gains mask inequities. There is also concern that the challenges of health care for the poor in the rapidly growing urban areas are not being met effectively.

The traditional power relationship between doctor and patient remains very much skewed towards the medical profession, making it difficult for many doctors to appreciate the contribution to improved health outcomes that can be made by patients individually and collectively and making it a difficult arena for citizens to express their concerns with confidence. It is also important to recognise that secondary and tertiary health care involves highly technical delivery systems and therefore that it is intrinsically difficult for providers and consumers to interact with mutual respect.

While GoB is committed to the principle of LLP, funding specifically dedicated to this purpose is very limited and has tended to produce tokenistic adherence to the process. It is probably seen by health professionals as a poor use of time since it is difficult to associate planning in isolation with practical improvements in health service delivery. Following the example of block grants to union level through the LGSP we believe there is scope for a supplementary or parallel scheme with funds earmarked for PHC.

The MOHFW is well designed as a technical ministry and has shown great success in this respect. Right down to the community level the staff of the Ministry are respected for their technical and clinical expertise. However, the Ministry is neither designed nor has a cultural inclination towards processes of community development. In this respect, communities look to elected representatives and the organs of local government as the local decision makers and problem solvers. This raises important questions about the best roles and relationships for the delivery of a primary care-based health system.

Therefore, not only is the CC initiative important because of its widespread and government-led characteristics but also because it creates an opportunity for easily observed and welcomed mutual benefits rather than antagonistic relationships. However, the politicisation of the programme creates potential problems.

4.4 Roles and relationships in community mobilisation

In a democratic society it is axiomatic that through representational processes citizens are able to influence the way in which public resources are used and private resources are regulated. While this is a matter of rights as well as efficiency, it is still proper to consider the cost of how this is achieved and the impact on functioning (for example, of health services).

Where the general held assumption – confirmed by reality – is that government will act in the general and impartial interest of citizens and the specific interests of the vulnerable, the executive branch can be expected to make arrangements for the hearing of voices and the legislative branch will act as a check on such arrangements as part of its role of holding the executive accountable.

Certainly until recently this has not been the general assumption about government in general and health services in particular. This is due to a general distrust of government, exercise of patronage by elected representatives, and a medical profession perceived to be driven by individual and collective self-interest. In these circumstances it has been seen as necessary and legitimate for independent third parties to fill substantially the democratic deficit as well as service deficiencies.

This way of doing business has a cost. Our estimate is that five years of support to a CCMG and CSGs would cost about US\$ 5,000 so scaling up to an additional 13,000 CCs would cost about US\$ 65 million over a five-year period.

Assuming that these same resources could have been deployed directly to health care, this also implies benefits foregone in terms of health services and health status. It thus follows that what these resources are used for is important. Personal appropriation or denial to patients of pharmaceuticals is a matter for criminal action; coming to work on time and staying for the required period is a contractual obligation; paying for posting, turning a blind eye to non-attendance, or procuring a clean audit is corruption. These matters are efficiently fixed by good government and strong management, not by citizen committee meetings.

On the other hand, making judgements about the quality of services, supporting good management, assisting service delivery, and promoting good health-seeking behaviours are both functionally contributive and provide real opportunity to exercise a voice.

It is also the case that the poorest and most vulnerable are the least well placed to have their voices heard and hold providers to account. The case for third parties is therefore undisputed. Instead, the more interesting and important questions are whether, to what extent, and at what pace there is a paradigm shift underway with a move towards supporting good government and strengthened management rather than looking to substitute for it.

5 Recommendations

5.1 Recommendations to government

- To maintain a vigorous approach to completing the programme of establishing a comprehensive network of CCs and associated CCMGs and CSGs.
- To work closely with MOLG so as to continue strengthening the links between CCMGs, union parishads, and upazila councils.
- To undertake operational research and implement effective measures for using new technologies to provide a route for community organisations to provide structured feedback about quality and utilisation of services.
- To review the operation of HMCs and adopt a more rigorous approach to monitoring their effectiveness and taking remedial measures when performance is not effective.
- To strengthen the GEVA-TG through the inclusion of line directors involved in major initiatives in V&A.
- To consider how the views of women users can be heard and incorporated into the design of voucher schemes and monitoring of implementation recommendations to DFID and DPs.

5.2 Recommendations to DFID and DPs

- To establish through the pooled funds a Community Health Development Fund to provide funding for third-party support to CCMGs and CSGs; block grants to provide for small discretionary expenditure based on LLP; and capacity strengthening of local government chairmen and councillors.
- To provide support through the pooled funds for a scheme to revitalise and strengthen schemes for hospital accountability to communities served. This should include technical assistance and capacity strengthening for the operation of HMCs and small grants to recognised hospital user forums and similar bodies.
- To provide financial support to think tank-style organisations proposing and then implementing schemes for providing expert knowledge support to community-level organisations and facilitating the exchange of information and good practices between such organisations.
- To work with the LD-MIS to explore and fund promising innovations in the use of new technologies to strengthen citizen voices.
- To explore options for improving the expert knowledge of health specialising journalists so that they are better informed of best practices and international experience

5.3 Recommendations to NGOs and civil society organisations

- Based on the learning from experiences so far, design low-cost but effective means of providing support to citizen groups.

- To explore means of collaboration, information exchange, and sharing of good practices in citizen participation in health.

Annex A Terms of reference

Terms of Reference Assessing Voice and Accountability (V&A) in Health Population and Nutrition Sector Development Programme (HPNSDP), 2011-16 DFID Bangladesh

1. Introduction

The Ministry of Health and Family Welfare (MoHFW), Government of Bangladesh (GoB) is currently implementing its third Health Sector Programme, known as *Health, Population and Nutrition Sector Development Programme* (HPNSDP), 2011-2016. The programme, supported by a host of Development Partners (DP) including DFID, aims to “*improve access to and utilization of essential health, population and nutrition services, particularly by the poor.*” (See **12. Background** for more details on the programme).

The principle of strengthening effectiveness and accountability of service provision through ‘participation’ has been introduced in the health sector programmes over the years but reviews to date have shown very slow progress in this area. HPNSDP, for example, proposes to incorporate the voice of the constituents by creating platforms like the District User Forum or the Community Clinic Management Groups and strengthen the ‘Gender, NGO, Stakeholder Participation and Partnership Unit’ (GNSPU) and develop a strategic framework for stakeholder participation but the 2012 annual programme review showed limited progress.

Outside the formal structures of the health sector programmes, several innovative interventions have demonstrated how participation and accountability in the health sector programme can be enhanced by building on and engaging with opportunities that have emerged from government commitments, even if implementation and follow-through has been limited.

In 2003, DFID commissioned a study to document some of these examples of effective citizen participation in influencing and improving the quality of health service delivery in Bangladesh (see **13. Reading Materials**). This assignment is both an update and an extension of that initiative, which produced a collection of case studies intended to inform citizen participation as a means of improving the responsiveness of services to user needs and public accountability.

2. Objective

To provide input to the HPNSDP Annual Programme Review in September 2013 on opportunities and options to enhance “voice and accountability” (V&A) in the health sector programme through:

- 7) Mapping current V&A initiatives, including those initiated outside the GoB structures, that build upon the scope of the health sector programme;
- 8) Preparing case studies with analysis of the strengths and limitations of influential V&A initiatives and the circumstances, factors and levers that increase their effectiveness and impact; and
- 9) Identifying feasible and constructive lessons learned and recommendations on V&A of relevance to HPNSDP and to DFID health sector programming in Bangladesh.

3. Recipients

The Ministry of Health and Family Welfare and DPs contributing to HPNSDP will be the recipients of the findings of this assessment. It will feed into the technical assistance provided through DFID Bangladesh funding to HPNSDP. The results will be shared with GoB policy makers, DPs and others – initially through the HPNSDP Annual Performance Review in September 2013.

4. Scope of the Work

Phase 1:

- 1.1. Undertake an initial scan of examples of existing initiatives in V&A in relation to the health sector programme – by government and/or civil society – and identify a sample of these for further detail review and analysis.

Selection should focus on identifying relatively successful initiatives that can offer lessons learned in terms of both design and implementation, and that may have the potential to be duplicated and/or scaled up in future. A preliminary classification of initiatives of interest would include:

- Approaches that directly **empower individuals** to take greater control over their lives and to hold their government to account;
- Approaches that **strengthen community action** to effectively engage in health service provision collectively mobilise and demand better services; and
- Approaches that **support accountable and responsive governance** through enhanced capacity of health service providers.

Phase 2:

2.1. Assess selected interventions against their intended objectives in terms of V&A:

Consider what has worked, how where and why, including the points of interface with the Government and benefits achieved by the different interventions, critical factors or conditions that have enabled influence, and scope to replicate the approach. Assess the relevance of the interventions for strengthening V&A in HPNSDP and other DFID health sector programmes, and options and opportunities for increasing the likelihood of success of relevant government-led initiatives.

Phase 3:

3.1. Identify a set of lessons learned and recommendations for future contributions to V&A initiatives in the health sector programme including:

- Recommendations for GoB that are feasible and applicable within the scope and available resources for HPNSDP;
- Recommendations for DPs that address both options for reducing/overcoming “supply side” obstacles and for promoting “demand side” engagement; and
- Recommendations for civil society that encourage learning from successful (and unsuccessful) past and ongoing experiences of promoting V&A in health sector service provision.

5. Methodology

The specific methodology will be designed by the consultants within one week of contract issue. This will be shared with DFID Bangladesh for review before proceeding with the work. The consultants should ensure that it takes into account the needs of a range of beneficiaries including urban and rural populations, national and sub-national service provision, and diverse beneficiary groups taking into account factors such as age, gender, education, geographic isolation, marginalisation and other vulnerability factors. The methodology must include:

- I. Literature Review
- II. In depth interviews including central level stakeholders and local level officials and service beneficiaries
- III. Field visits to at least five sites

6. The Requirements and Team Structure

Deliverables:

On conclusion of Phase 1 (no later than 10th July 2013)

- 1.1. A summary of examples of current initiatives in V&A in the health sector and recommendation for interventions to include in Phase 2.
- 1.2. Presentation of interim findings to DFID Bangladesh and interested DPs.

On conclusion of Phase 2 (no later than 30th August 2013):

- 2.1. Interim Report (max 10pp plus Executive Summary and Annexes) on assessment of selected interventions including at least 5 in-depth case studies.
- 2.2. Presentation of interim findings to DFID Bangladesh and interested DPs.

On conclusion of Phase 3 (no later than 12th September 2013):

- 3.1. Final Report (max 15pp plus Executive Summary and Annexes), including recommendations for GoB, DPs and civil society implementing partners.
- 3.2. Debrief presentations to DFID, GoB and DPs.

Team Structure: The team should comprise one international consultant (team leader) and one national consultant. The team members should have the following experience between them:

- Comparative international experience in V&A in the health sector;
- Strong understanding of, and experience working with, the health sector in Bangladesh;
- Experience in engagement with both government and civil society;
- Experience of V&A programme design and/or programme evaluation;
- Experience of an assessment for DFID or another leading development donor.
- Substantial relevant professional expertise; and
- Fluent English and preferably Bangla. At least one team member should have proven ability to write in English for a public audience.

Duration: The maximum number of working days for the assignment is 33 days for the international consultant (including maximum 24 working days in country) and 20 for the national consultant. This is based on a 6-day working week.

7. Constraints/Dependencies

The HPNSDP Annual Performance Review is due in September 2013 and the findings of this assessment need to be ready to feed into that process. Ramadan will be from 9 July to 7 August (tentative dates) in 2013 and is expected to place some restrictions on availability for meetings and travel options.

As a result of the above restrictions on timing, we recommend that in-country work be completed by 9 July 2013 (see approximate timeframe below).

The Bangladesh Parliamentary Elections are due between October 2013 and January 2014. We anticipate some restrictions on mobility prior to and during the elections and we are already experiencing frequent *hartals* (general strikes). The consultants should be prepared to adapt accordingly.

8. Timeframe

The consultants are expected to define details of timing within the following timeframe:

- Contract finalised by 10th June 2013
- Work in-country completed between 17 June and 30th August 2013
- Final reporting completed by 12th September 2013

The timing of in-country visits must be agreed in advance with DFID Bangladesh.

9. Coordination/Logistics

The consultancy will be carried out under general guidance of DFID Bangladesh. The team will be entirely responsible for its own logistical arrangements including their own programme of meetings and activities, transport, meeting space, hotel bookings and visa applications. An invitation letter to support a visa application can be provided on request.

10. Management and Reporting

The team will report to DFID Bangladesh Governance Adviser, Helen Barnes.

Contract administration and payment will be managed by Deputy Programme Manager, Nushrat Ahmed, on behalf of DFID.

11. Duty of Care

The consultants' firm will be responsible for the safety and well-being of its personnel and third parties affected by their activities under this contract, including appropriate security arrangements.

They will also be responsible for the provision of suitable security arrangements for their domestic and business property.

DFID will share available information with the consultants on security status and developments in-country where appropriate. DFID will provide the following:

- All consultants will be offered a security briefing by the British Embassy/DFID on arrival. All international consultants must register with their respective Embassies to ensure that they are included in emergency procedures.
- A copy of the DFID visitor notes (and a further copy each time these are updated).

The consultants' firm is responsible for ensuring appropriate safety and security briefings for all of its personnel working under this contract and ensuring that their personnel register and receive briefing as outlined above. Travel advice is also available on the FCO website and the consultants' firm must ensure they (and their personnel) are up to date with the latest position.

12. Background

The Health Sector Programme

The UK is working with GoB and 15 other donors to implement a comprehensive programme of reforms through *Health, Population and Nutrition Sector Development Programme (HPNSDP)*, 2011-2016, to deliver further improvements in health including increased access to better quality health services, especially for the poor in underserved areas. The programme focusses on essential services (reproductive, adolescent, maternal, neonatal and child health and family planning, nutrition, communicable and non-communicable diseases) in addition to scaling up work on nutrition, especially for pregnant women and children, and improving surveillance, control and treatment of communicable diseases including TB, malaria and HIV/AIDS. Recognising the growing burden of non-communicable diseases like diabetes and hypertension, the programme also aims to improve diagnosis and surveillance of these, and encourage behaviour that helps prevent illness.

To make sure improvements are sustainable and resources achieve the maximum impact, the programme is tackling weaknesses in the health system. This ranges from planning, budgeting and procurement to supply chain management and human resource management to make sure more drugs and doctors and nurses reach those who need them. It also encourages mechanisms that give local people more chance to say whether services are meeting their needs. This Health Programme is complemented by other UK interventions in Bangladesh, including partnerships with NGOs who deliver community health, water and sanitation and education services in remote areas and urban slums, and a programme working across the government to improve management of public finances and revenue collection.

Health sector programming and V&A

HPNSDP's predecessor – *Health, Nutrition and Population Sector Programme (HNPS)*, 2003-2011, the second Sector Wide Approach (SWAp), emphasised reforms that included greater V&A in the programme in the form of 'Community Clinic Management groups' that included members of the local government (union council) as well as women and poor representatives as mandatory members. This was built on the earlier pilot experience of mobilising communities and building their capacity to oversee service provision and increase accountability of the front line workers at the grassroots level. However with the change of government in 2001 and accompanying change of policy, much of the above initiative could not be implemented. Spaces to hear from users of public services have also been opened in theory in the 'District Users Fora', in the union level 'Family Planning Committee', the Parliamentary Standing Committee on Health, Local Level Planning interventions, in various health facility surveys and reviews of the sector programmes etc. A Citizen's Charter of Health (CCH) was formulated and later revised in 2007.

Health, Population and Nutrition Sector Development Programme (HPNSDP), 2011-16, reiterates the previous policy emphasis on providing a platform to the communities to voice their issues and hold public servants accountable. The current government created the 'Community Clinic Project'

and provided funds to implement the initiative while the design of HPNSDP was being developed. Guidelines for formation of the community clinic group and its mandate and a training manual have been developed. HPNSDP also acknowledges the need for strengthening gender, equity and expanding its collaboration with the civil society organisations (non-state sector) to achieve its objectives. The design of HPNSDP has included the forming a Gender NGOs, Stakeholder Participation and Partnership Unit (GNSPU) and developing a strategy for 'public-private-partnership'. In recognition of the need to address Gender, Equity, Voice and Accountability throughout implementation, HPNSDP has established a Gender, Equity, Voice and Accountability (Task Group (GEVA TG), co-chaired by the Joint Chief of the Health Economics Unit and by SIDA. Represented donors include: AusAID, DFID, GIZ, Netherlands, SIDA, UNICEF and WHO.

There is a considerable gap between theory and practice, however, and most government-led mechanisms for participation and accountability do not function as intended. The disconnect between service providers and the public is exacerbated by the underfunding of the sector programmes. As a result, the general public tends to express unrealistic expectations in the stakeholder consultations that have been held as part of annual reviews.

13. Reading materials/reference material

- Deborah Thomas, *Citizen Participation and Voice in The Health Sector In Bangladesh*. DFID, Final Report, 2003.
- HPNSDP Project Implementation Plan Doc
- Stakeholder Consultation Report, Annual Review 2012

HPNSDP Annual Performance Review Aide Memoire 2012

Annex B Literature review



HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Voice and accountability in the health sector

Date: 31 May 2013

Query: Write a report to identify: 1) Useful sources on assessment of V&A; Examples of V&A in the Bangladesh health sector; and 3) Different models of V&A.

Purpose: To provide background for call-down work

Contents

1. Assessment of V&A in the health sector
2. Assessment of specific V&A initiatives in health sector
3. V&A in the Bangladesh health sector
4. Models of V&A
5. Additional information

1. Assessment of voice and accountability in the health sector

A systematic review of the literature for evidence on health facility committees in low- and middle-income countries

McCoy D, Hall J, Ridge M. 2012. Health Policy and Planning 27:449–466

<http://heapol.oxfordjournals.org/content/early/2011/12/08/heapol.czz077.short?rss=1>

Community participation in health (CPH) has been advocated as a health-improving strategy for many decades. CPH comes in many different forms, one of which is the use of health facility committees (HFCs) on which there is community representation. This paper presents the findings of a systematic literature review of: (a) the evidence of HFCs' effectiveness, and (b) the factors that influence the performance and effectiveness of HFCs. Four electronic databases and the websites of eight key organisations were searched. Out of 341 potentially relevant publications, only four provided reasonable evidence of the effectiveness of HFCs. A further 37 papers were selected and used to draw out data on the factors that influence the functioning of HFCs.

A conceptual model was developed to describe the key factors. It consists of, first, the features of the HFC, community and facility, and their interactions; second, process factors relating to the way HFCs are established and supported; and finally, a set of contextual factors. The review found some evidence that HFCs can be effective in terms of improving the quality and coverage of health care, as well as having an impact on health outcomes. However, the external validity of these studies is inevitably limited. Given the different potential roles/functions of HFCs and the complex and multiple set of factors influencing their functioning, there is no 'one size fits all' approach to CPH via HFCs, nor to the evaluation of HFCs. However, there are plenty of experiences and lessons in the literature which decision makers and managers can use to optimise HFCs.

Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework

Molyneux, S., Atela, M., Angwenyi, V, Goodman, C., 2012. Health Policy Planning, 27 (7)

<http://heapol.oxfordjournals.org/content/27/7/541.full.pdf+html>

Public accountability has re-emerged as a top priority for health systems all over the world, and particularly in developing countries where governments have often failed to provide adequate public sector services for their citizens. One approach to strengthening public accountability is through direct involvement of clients, users or the general public in health delivery, here termed 'community accountability'. The potential benefits of community accountability, both as an end in itself and as a means of improving health services, have led to significant resources being invested by governments and NGOs. Data are now needed on the implementation and impact of these initiatives on the ground. A search of PubMed using a systematic approach, supplemented by a hand search of key websites, identified 21 papers from low- or middle-income countries describing at least one measure to enhance community accountability that was linked with peripheral facilities. Mechanisms covered included committees and groups ($n = 19$), public report cards ($n = 1$), and patients' rights charters ($n = 1$). In this paper the authors summarise the data presented in these papers, including impact, and factors influencing impact, and conclude by commenting on the methods used and the issues they raise. Key influences on the impact of the community engagement activities are:

- How committee and group members are selected and their motivation for involvement;
- The relationship between groups or committees, health workers and health managers; and
- Provision of adequate resources and support by local and national governments.

The authors highlight that the international interest in community accountability mechanisms linked to peripheral facilities has not been matched by empirical data, and present a conceptual framework and a set of ideas that might contribute to future studies.

The income elasticity of health care spending in developing and developed countries

Marwa Farag, M., Nanda Kumar A.K., Wallack, S., Hodgkin, D., Gaumer, & G., Erbil, C. 2012, *Int J Health Care Finance Econ*, 12:145–162

<http://link.springer.com/article/10.1007/s10754-012-9108-z#page-1>

To date, international analyses on the strength of the relationship between country level per capita income and per capita health expenditures have predominantly used developed countries' data. This study expands this work using a panel data set for 173 countries for the 1995–2006 period. The authors find that health care has an income elasticity that qualifies it as a necessity good, which is consistent with the results of the most recent studies. Health care spending is least responsive to changes in income in low-income countries and most responsive in middle-income countries, with high-income countries falling in the middle. Finally, it was found that V&A as an indicator of good governance seems to play a role in mobilising more funds for health.

V&A had a significant impact on mobilising more funds for health in South America but the variable was not significant in other continents (albeit positive). The role of V&A has not been explored much in the literature in the context of health care. However, it has been found that V&A can strengthen the sustainability of conditional transfer programmes in Latin American countries through improved oversight over programme implementation as well as the use of funds. Latin American countries as a group seem to have experienced considerable improvements in this area compared to other countries over the time period of the study. This finding is intriguing and prompts further investigation into the role that V&A can play in mobilising more funds for health in South America using more in-depth data from this region.

Challenges to fair decision-making processes in the context of health care services: a qualitative assessment from Tanzania.

Shayo, E.H, Norheim, O.F., Mboera, L.E.G., Byskov, J., Maluka, S., Kamuzora, P., Blystad., A. 2012, *International Journal for Equity in Health*, 11: 30

<http://www.biomedcentral.com/content/pdf/1475-9276-11-30.pdf>

Fair processes in decision making need the involvement of stakeholders who can discuss issues and reach an agreement based on reasons that are justifiable and appropriate in meeting people's needs. In Tanzania, the policies of decentralisation and health sector reform place an emphasis on community participation in making decisions in health care. However, aspects that can influence an individual's opportunity to be listened to and to contribute to discussion have been researched to a very limited extent in low-income settings. The objective of this study was to explore challenges to fair decision-making processes in health care services with a special focus on the potential influence of gender, wealth, ethnicity and education. The study draws on the principle of fairness as outlined in the deliberative democratic theory.

The study was carried out in the Mbarali District of Tanzania. A qualitative design was used. In-depth interviews and focus group discussions were conducted among members of the district health team, local government officials, health care providers and community members. Informal discussion on the topics was also of substantial value.

The study findings indicate a substantial influence of gender, wealth, ethnicity and education on health care decision-making processes. Men, wealthy individuals, members of strong ethnic groups and highly educated individuals had greater influence. Opinions varied among the study informants as to whether such differences should be considered fair. The differences in levels of influence emerged most clearly at the community level, and were largely perceived as legitimate.

Existing challenges related to individuals' influence over decision-making processes in health care need to be addressed if greater participation is desired. There is a need for increased advocacy and a strengthening of responsive practices with an emphasis on the right of all individuals to participate in decision-making processes. This simultaneously implies an emphasis on assuring the distribution of information, training and education so that individuals can participate fully in informed decision making.

Strengthening Voice and Accountability in the Health Sector

DFID. 2008. PATHS Technical Brief.

http://www.healthpartners-int.co.uk/our_expertise/documents/Voiceandaccountability.pdf

V&A really matters if health services are to be improved. Knowing how, when and where to intervene to strengthen citizen V&A within the health sector is challenging in contexts where health systems are very weak and many issues require urgent attention. Partnerships for Transforming Health Systems Programme (PATHS) is funded by DFID and was implemented in Nigeria in 2002. This Technical Brief looks at how seven different systems strengthening and service delivery improvement initiatives helped strengthen citizen participation and voice, and enhanced accountability in the PATHS states over the period 2003 to 2008. The authors found that involving members of the community in the governance of health facilities through facility health committees proved an effective way to progress a V&A agenda. However, to ensure that these committees functioned effectively, considerable capacity-building support, in the form of formal training and ongoing mentoring support, was required. The quality of community participation in Facility Health Committees (FHCs) was low in the PATHS states that relied on a one-off training, whereas in Kaduna, where the support was more broad-ranging and extensive, early results pointed to some interesting V&A outcomes.

Initiatives that provided formal mechanisms through which citizen voices could reach health providers and policy-makers appeared to offer the most potential from a V&A perspective. In the PATHS states these initiatives not only placed an obligation on different parts of government to listen to the voice of the people but also introduced incentives to respond. In contrast, initiatives that relied on citizens trying to influence policy-makers via informal routes (e.g. the safe motherhood demand-side initiative and FHCs) could not guarantee that citizens would get an audience with a policy-maker, while getting a response appeared to depend on a policy-maker's personal initiative or whim. Such initiatives are likely to fail in the absence of parallel efforts to strengthen public accountability at local government level. This highlights the importance of timing work on V&A so that it links in with other initiatives that aim to strengthen performance management and public accountability at local government level.

Civil society organisations, such as NGOs and CBOs, have a potentially important role to play in creating space for voice and catalysing changes in accountability between providers, policy-makers and communities. This requires further exploration as new V&A initiatives are designed and implemented.

Community-directed interventions for priority health problems in Africa: results of a multicountry study

The CDI Study Group, 2010, Bulletin of the World Health Organization (88)

<http://www.who.int/bulletin/volumes/88/7/09-069203/en/index.html>

A Community-Directed Intervention (CDI) is one that is undertaken at the community level under the direction of the community itself. Initially, local health services and their partners introduce the range of possible interventions in a participatory manner and explain the community-directed approach and how it can ensure community ownership from the outset. Subsequently, the community takes charge of the process, usually through a series of community meetings where the roles and responsibilities of the community in the CDI process are discussed and the community decides how, when and where the intervention will be

implemented and by whom, how implementation will be monitored, and what support (financial or otherwise), if any, will be provided to implementers. The community then collectively selects the implementers. Health workers train and monitor the latter, but the community directs the intervention process.

This study was designed to evaluate the effectiveness, cost and process of progressively adding four established health interventions of different complexity to the CDI process already used for the delivery of ivermectin. Quantitative survey methods were used to evaluate effectiveness and cost, and qualitative methods were used to evaluate processes.

Effectiveness: In both years of the study the coverage for vitamin A supplementation, insecticide-treated nets and home management of malaria was significantly higher when delivered through the CDI process. The increased coverage was particularly striking for the antimalarial interventions. While very low in the comparison districts, it nearly doubled when delivered through CDI.

Costs: At the district level, cost analysis suggests that delivering health care interventions through the CDI process is relatively cost-efficient. There was little difference in the relative allocation of costs between CDI trial sites and comparison districts. In both cases, staff salaries comprised the major cost (51.2% versus 48.6%, respectively). Maintenance, training and social mobilisation each accounted for 10–17% of costs in both groups of districts. The cost of transport comprised less than 3% in the CDI districts and about 8% in the comparison districts.

At the first-line health facility level, the CDI strategy did not result in significant cost savings. While costs were slightly lower in the CDI districts (median: US\$ 1,025) than in the comparison districts (median: US\$ 1,170), the difference was not statistically significant. In this case as well, staff salaries were the costliest component.

Critical process factors: Implementing the CDI strategy involved five major processes at different levels of the health system. The authors evaluated stakeholder processes, health system dynamics, engaging and empowering communities, engaging community implementers, and the effect on broader systems. The authors found that stakeholder identification and consultation at all levels of the health system was critically important for the success of the CDI strategy, and that the degree of consensus increased over time as the CDI process matured. The participatory consultation and sensitisation process and the improved availability of intervention materials led to an increased commitment on the part of the health system to the CDI process at all levels in all seven sites.

Integrated delivery of different interventions through the CDI strategy proved feasible and cost-effective where adequate supplies of drugs and other intervention materials were made available. Communities, health workers, policy-makers and other stakeholders were quite supportive and their buy-in to the CDI approach increased significantly over time. Since intervention coverage also increased as more interventions were gradually included in CDI delivery, the results of the study are promising in terms of the sustainability of the CDI approach.

Assessing the impact of Health Centre Committees on health system performance and health resource allocation

Loewenson R, Rusike I, Zulu M (2004) EQUINET Discussion Paper 18. Harare, Zimbabwe
<http://www.equinet africa.org/bibl/docs/DIS18%20res.pdf>

In this study in Zimbabwe, four wards serviced by clinics with a Health Centre Committee (HCC) were compared with four wards with clinics without a HCC. Clinics with HCCs had, on average, more staff and there was some evidence of higher budget allocations from the Ministry of Health and Child Welfare than those without HCCs. They also had more EPI campaigns than those without HCCs. Drug availability at the clinics with HCCs was better than those without HCCs, although drug availability was generally poor. It could be argued that improved health performance and staffing in these areas is associated with an improved capacity to draw on and use health resources. If this is the case then there is a virtuous cycle for those clinics with HCCs and a vicious cycle for those without.

The study indicated also that areas with HCCs performed better on PHC statistics (environmental health technician visits and oral rehydration salts use) than those without, and that there is improved contact with the community in areas with HCCs. Community health indicators (health knowledge, health practices, knowledge and use of health services) were higher in areas with HCCs than in those without. Communities in areas with HCCs had a better knowledge of the organisation of their health services from the indicators

assessed, making services more transparent to them. There was also evidence of improved links between communities and health workers in these areas.

HCCs have not had direct influence over core health budgets and have little influence in how their clinics are managed and run. The improved resources to clinics in areas with HCCs indicates some indirect association between HCCs and primary care resources. This may be exerted through support for clinic security, for staff needs, for clinic facilities and outreach and other services.

2. Assessment of specific voice and accountability initiatives in health sector

Community participation and voice mechanisms under performance-based financing schemes in Burundi

Falisse J, Meessen B, Ndayishimiye J, Bossuyt M. 2012. *Tropical Medicine and International Health* 17(5) pp 674-682

<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-3156.2012.02973.x/full>

This paper analyses the roles of two community accountability mechanisms in a Performance-Based Financing (PBF) scheme. It evaluates 100 health committees and 79 CBOs in six Burundi provinces (2009–2010) and a framework based on the literature on CPH and New Institutional Economics.

The CBOs involved are existing local organisations, set up for other purposes (e.g. cooperatives, charities, etc.) They were selected through a bidding process by peer organisations or by a panel of experts. They are offered quarterly contracts by the Purchasing Agency to 'authenticate' with randomly selected users the declarations of the health centres on patients and care. The data collected through CBOs' verification regard (i) the existence of the users, (ii) the existence of the treatment these users received, (iii) their perception of the price, (iv) their perception of the quality of the services, and (v) their possible comments. This information is reported directly to the Purchasing Agency that pays CBOs between US\$ 1 and US\$ 2 per validated questionnaire.

PBF schemes also use pre-existing health committees (Comité de Santé, COSA). COSA members are representatives elected by the population living in the catchment area of a health centre. COSA's role is defined as participating in (i) technical co-management of the health facilities (mostly planning and evaluation), (ii) administrative co-management (including controlling the finances), (iii) promotion in the population, and (iv) other (unspecified) activities. COSA's members are invited, along with the health centre's medical staff, to design the health centre quarterly development plan. This plan includes a decision on the allocation of the funds received through the PBF scheme.

This paper discusses how these two community participation mechanisms function in practice through the results of a recent survey. The authors conclude that the health committees appear to be rather ineffective, focusing on supporting the medical staff and not on representing the population. CBOs do convey information about the concerns of the population to the health authorities; however, they represent only a few users and lack the ability to force changes. PBF does not automatically imply more 'voice' from the population, but introduces an interesting complement to health committees with CBOs. However, important efforts remain necessary to make both mechanisms work. More experiments and analysis are needed to develop truly efficient 'downward' mechanisms of accountability at the health centre level.

Health facility committees and facility management – exploring the nature and depth of their roles in Coast Province, Kenya

Goodman, C., Opwora, A., Kabare, M., & Molyneux, S. (2011) *BMC Health Services Research* 11:229

<http://www.biomedcentral.com/1472-6963/11/229>

This paper explores the nature and depth of the roles of HFCs in two rural districts of the Coast Province in Kenya through interviews with health workers, committee members, patients and district managers, and evaluates how they have contributed to community accountability. Structured interviews were conducted with the health worker in charge and with patients in 30 health centres and dispensaries. In-depth interviews with health workers and HFC members included a participatory exercise to stimulate discussion of the nature and depth of their roles in facility management.

While the HFC members described their work in the facility as largely voluntary, Direct Facility Financing allowances were seen as partially compensating members for the time spent on health-related activities, thus increasing commitment to facility management and improving general committee functioning. However, allowances were still viewed as insufficient in many cases, with several HFC members recommending that they be increased, or introduced where they were currently not provided.

The authors reported that the HFCs were generally functioning well and played an important role in facility operations. The breadth and depth of engagement had reportedly increased after the introduction of direct funding of health facilities, which allowed HFCs to manage their own budgets. Although relations with facility staff were generally good, some mistrust was expressed between HFC members and health workers, and between HFC members and the broader community, partially reflecting a lack of clarity in HFC roles. Moreover, over half of exit interviewees were not aware of the HFC's existence. Women and less well-educated respondents were particularly unlikely to know about the HFC.

The authors concluded that there is potential for HFCs to play an active and important role in health facility management, particularly where they have control over some facility-level resources. However, to optimise their contribution, efforts are needed to improve their training, clarify their roles, and improve engagement with the wider community.

Power to the People: Evidence from a Randomized Field Experiment of a Community-Based Monitoring Project in Uganda

Björkman, M. & Svensson, J., 2007, Quarterly Journal of Economics

http://www.cid.harvard.edu/neudc07/docs/neudc07_s2_p11_bjorkman.pdf

Strengthening the relationship of accountability between health service providers and citizens is viewed by many people as critical for improving access to and quality of health care. How this is to be achieved, and whether it works, however, remain open questions. To examine whether beneficiary control works, the authors designed and conducted a randomised field experiment in 50 'communities' from nine districts in Uganda. In the experiment, or intervention, communities were provided with baseline information on the status of service delivery, both in absolute terms and relative to other providers and the government standard for health service delivery. As a way to mitigate local collective action problems, community members were also encouraged to develop a plan that identified the most important problems in health service provision and ways to monitor the provider.

The intervention resulted in 1.7 percentage points fewer child deaths in the treatment communities during the first project year. To the extent that this number is representative of the total treatment population, this would imply that approximately 550 under-5 deaths were averted as a result of the intervention. A back-of-the-envelope calculation then suggests that the intervention, only judged on the cost per death averted, must be considered to be fairly cost-effective.

As communities began to more extensively monitor the provider, both the quality and quantity of health service provision improved. The findings on staff behaviour suggest that the improvements in quality and quantity of health service delivery resulted from an increased effort by the staff to serve the community. Overall, the results suggest that community monitoring can play an important role in improving service delivery when traditional top-down supervision is ineffective.

Community participation in population-based non-insulin dependent diabetes mellitus control program: A paradigm

Abanobi, O. 2012. International NGO Journal 7(1), pp 1-8

<http://www.academicjournals.org/INGOJ/contents/2012cont/May.htm>

A paradigm for community participation in population-based non-insulin-dependent diabetes mellitus (NIDDM) control programme being used in rural south-eastern Nigeria is presented. The paradigm features the use of area PHC district health committees as Community-based Diabetes Control Implementation Committees. It also calls for the deployment of village health workers/volunteers as Community-based Diabetes Control Workers with responsibility for suspect case search, community mobilisation, blood-sugar monitoring and referral, and health education. The model integrates population-based NIDDM into an area PHC system. It also aligns control activities with traditional authority hierarchies and the political processes of rural communities. The experience from the implementation of the paradigm in five communities in south-

eastern Nigeria is presented. Implications for achieving long-term sustenance, relating diabetes control to prevailing socio-cultural norms and practices as well as for demystification of diabetes control are discussed.

Health care access of the very poor in Kenya. Workshop Paper 11. Meeting the health related needs of the very poor, DFID Workshop 14–15 February. Kenya: Aga Khan Health Service.

Sohani, S. 2005. DFID workshop paper.

http://www.eldis.org/fulltext/verypoor/11_agakhan.pdf

This paper describes a before-and-after intervention study in two districts of the Coast Province of Kenya. The intervention consisted of organising local communities to form representative Dispensary Health Committees (DHCs) that would allow people to govern the health and development activities at the dispensary level. The DHCs were given authority to manage revenue generated from user fees, to establish fee levels and to shape the local policy for user fee exemptions and waivers. Other functions included identifying and supporting village health workers; facilitating outreach health care and health education; and helping to improve the supply of essential drugs.

The intervention was found to have had a number of positive impacts. Health care utilisation and revenue generation increased in all clinics. The original model at six sites in Kwale implemented in 1998 to 2000 showed a significant increase in utilisation of the preventive and promotive services and in the revenue collection at various sites. At the same time, cost barriers for the poorest were reduced through the more effective implementation of fee exemptions and deferrals.

The study concluded that a pro-poor health system can be developed if the true representatives of the poorest are enabled to participate in health care delivery and good governance and proper systems are established, and that semi-literate community members can be trained to collect, aggregate and use health and financial information for decision making and taking corrective action against the misuse and appropriation of scarce resources.

Examining the links between accountability, trust and performance in health service delivery in Tanzania. Consortium for Research on Equitable Health Systems (CREHS). Ifakara Health Institute, Tanzania.

Macha, J., Mushi, H., Borghi, J. 2011. CREHS.

http://www.crehs.lshtm.ac.uk/tan_accountability12jul.pdf

Health Facility Governing Committees (HFGCs) are run within health facilities of all levels of the health system in Tanzania. The aim of this study was to examine the pre-conditions for the effective functioning of the committees, both in terms of representing community voice and in improving health worker performance and resource mobilisation in relation to the Community Health Fund (CHF), a voluntary health insurance scheme over which the committees have some responsibility. This report examines case studies of a 'well performing committee' and a 'less performing committee' in Ulanga District.

Both committees had some impact on health worker performance in terms of health worker availability and opening hours. The impact of the committees on resource mobilisation was examined in terms of how money was spent by the committees. In Kivukoni, the committee approached the district about drug shortages but no response was received. In Sofi Majiji, the committee approached the district about drug shortages and was encouraged to use CHF money to purchase more drugs. Efforts to mobilise communities to join the CHF were mostly undertaken by health care providers in both sites, although this is officially a role of the HFGCs. In Sofi Majiji, the committee also mobilised labour from the community for construction of the health facility and provider houses. They managed to levy funds from an NGO to support construction activities. In both sites, the committees managed to use user fee funds to finance small expenses at the facility, with Sofi Majiji also managing to use CHF money to buy drugs. Generally, however, the committees were limited in their availability to decide how to spend user fee and CHF revenue.

One constraint against effective action of the HFGC identified in this study is the absence of meeting and transport allowances. Committee members can be unwilling to give up their time in the absence of allowances to attend meetings or activities.

A summary of this study is available at:

http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/docs/reseources/Health%20Facility%20Committees_Are%20they%20working.pdf

A Rough Guide to Community Engagement in Performance-Based Incentive Programs: With Lessons from Burundi, Indonesia, and Mexico. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.

Morgan, L. 2012. USAID.

http://www.healthsystems2020.org/files/92722_file_CE_Guide_5_editor_MA_FINAL_mm.pdf

The role of CBOs in verifying health centres' performance in Burundi is described in this paper. Verifying the results for every health facility in a country (even one as small as Burundi) implies significant costs; engaging CBOs to carry out this function is likely to be significantly cheaper than other independent auditing agencies – not only because their professional fee expectations are lower but also because the programme does not incur the same magnitude of transportation costs, since the CBOs are physically closer to households.

In Mexico, the *Oportunidades* conditional cash transfer (CCT) programme provides cash stipends to mothers in poor households, conditional on them ensuring that each family member attends a health check-up once a year, that their children attend school, and that the mothers attend a monthly class on health topics. Volunteer programme beneficiaries, known as *vocales*, are engaged as local arms of programme administration, providing participants with programme information and conducting workshops on self-help topics. In terms of oversight, *vocales* see their role predominantly as one that ensures beneficiary compliance with the programme, and less one of oversight of any other entity (for example, health providers). Engaging the *vocales* to administer the programme at the local level effectively cuts the cost of implementation. The lowest level of programme staff in *Oportunidades* are the *Responsable de Atención* (RA), who are responsible for overseeing large numbers of beneficiaries: in one locality called Queretaro, for example, there are 25 RAs who each coordinate an average of 3,600 households. By contrast, the almost 250,000 registered *vocales* in the *Oportunidades* programme represent on average 25 beneficiary families each. Replacing them with paid staff would increase the cost of administering *Oportunidades* considerably.

However, this apparent cost saving is not as straightforward as it might appear at first glance. In Burundi, for example, the Performance-Based Incentive (PBI) unit in the Ministry of Health decided in 2011 to reduce the frequency of verification – from once per quarter to twice per year – while maintaining the household sample size (80 households per facility), thus effectively reducing the sample. Part of the reason for doing so was to give CBOs sufficient time to conduct the surveys, and the provincial authorities sufficient time to analyse the results, but the decision was also driven by the substantial financial and administrative costs of conducting quarterly verification. Verifying results is at the heart of any PBI scheme: paying for reported results gives providers an incentive to over-report, and thus it is essential to verify and counter verify what is reported.

Regarding the role of the *vocales*, their importance creates enormous potential for the abuse of power, yet their supervision is extremely limited. This is partly due to cost. Additionally, *vocales* sometimes ask participants for volunteer contributions, or to give them a portion of their cash transfer, to reduce the cost of materials, food, and travel they undertake as part of their duties. This may point to a programme design issue: programmes cannot expect volunteers to incur expenses to conduct the functions they are responsible for.

The bottom line is that even if engaging communities saves money in terms of the direct costs of hiring them, there are nonetheless other costs related to the function and role the community is playing that must be considered if the function is to be robust. In the Mexican example, these costs may include budget for more and better training for *vocales*, including training on how to report 'up' to the programme; for visits by higher-level authorities to check on the programme; in advertising channels among beneficiaries where they can report abuse by *vocales*; and even by paying *vocales* modest salaries for their work.

In regard to the CBOs' role in verification, these costs certainly include the cost of conducting verification at a frequency that will ensure the programme is paying only for real, verified results and the cost of counter-verifying what the CBOs report. For example, in Senegal, CBOs make quarterly visits to households to, as in Burundi, verify results reported by health facilities – however, in the subsequent quarter an external auditing agency also counter-verifies a small sample of households, i.e. goes back to the household to ensure the CBO in fact made the visit and recorded the information accurately.

The female community health volunteer programme in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives

Claire Glenton, C., Scheel, I.B., Pradhan, S., Lewin, S., Hodgins, S., Shrestha, V. 2010. Social Science and Medicine. 70 (12): 1920–1927
<http://www.sciencedirect.com/science/article/pii/S027795361000198X>

The Female Community Health Volunteer (FCHV) Programme in Nepal has existed since the late 1980s and includes almost 50,000 volunteers. Although volunteer programmes are widely thought to be characterised by high attrition levels, the FCHV Programme loses fewer than 5% of its volunteers annually. The degree to which decision makers understand community health worker motivations and match these with appropriate incentives is likely to influence programme sustainability.

The purpose of this study was to explore the views of stakeholders who have participated in the design and implementation of the FCHVs regarding volunteer motivation and appropriate incentives, and to compare these views with the views and expectations of volunteers. Semi-structured interviews were carried out in 2009 with 19 purposively selected non-volunteer stakeholders, including policy-makers and programme managers. Results were compared with data from previous studies of FCHVs and from interviews with four volunteers and two volunteer activists. Stakeholders saw volunteers as motivated primarily by social respect and religious and moral duty. The freedom to deliver services at their leisure was seen as central to the volunteer concept. While stakeholders also saw the need for extrinsic incentives such as micro-credit, regular wages were regarded not only as financially unfeasible but as a potential threat to the volunteers' social respect, and thereby to their motivation. These views were reflected in interviews with and previous studies of FCHVs, and appear to be influenced by a tradition of volunteering as moral behaviour, a lack of respect for paid government workers, and the programme's community embeddedness.

This study suggests that it may not be useful to promote a *generic* range of incentives, such as wages, to improve community health worker programme sustainability. Instead, programmes should ensure that the context-specific expectations of community health workers, programme managers, and policy-makers are in alignment if low attrition and high performance are to be achieved.

3. Voice and accountability in the Bangladesh health sector

Voice and Accountability: The Role of Maternal, Neonatal and Child Health Committee

Rashid, S., Leppard, M., Nasreen, H.E., Akther, M. & Rahman, A. 2011. Bangladesh Rural Advancement Committee (BRAC) working paper no. 26
http://research.brac.net/workingpapers/red_wp26_new.pdf

This study explores how the MNCH committee encouraged community participation and how its communication activities empower the community to ensure the health care needs of the poor and disadvantaged people are met. A range of qualitative methods was used in the study. In-depth interviews, focus group discussions, informal discussions, observation and document review were used as data collection methods. This study was conducted in two sub-districts of the Nilphamari and Mymensingh districts of Bangladesh during February to April 2010. A thematic content analysis technique was employed.

Findings reveal that the committee members took necessary steps to solve maternal complications by referral, follow-up of referred cases, and providing financial support to the extreme poor if needed, and the committee helped increase the availability of health care service providers and improve the nature of services accessible to the community. However, the capacity of the committees to raise the voice of poor people was fairly limited due to lack of adequate orientation of the committee members and also a lack of publicity about their roles. Moreover, the committee could not run properly due to disagreement between power and literacy among the committee members.

The MNCH committee displayed some potential as it allowed the people's voice to be raised and could, thus, serve as a pathway through which ordinary people could hold local health authorities and local service providers to account. The findings informed the further development of an enabling environment in which the voices of MNCH committee members and community people would be stronger.

Harnessing Technology to Strengthen Accountability

Allen, J. et al. 2012. The National Bureau of Asian Research.
http://www.pacifichealthsummit.org/downloads/2012_Summit/Accountability.pdf

Case Study example: Bangladesh, SMS and teleconferencing

With 800 public hospitals, ensuring patient satisfaction in one of the world's most densely populated countries is a challenge, but a team at the MOHFW in Bangladesh has designed a text messaging programme that gives patients a voice. "We placed sign boards in all our hospitals that describe how to send complaints or suggestions for improving health care services via SMS," said Abul Kalam Azad, Director of Management Information Systems for the MOHFW.

The messages, which total around 1,000 received per day, are aggregated in a web portal monitored by MOHFW staff. The complaints, said Azad, range from absent hospital employees and poor patient–doctor/nurse interaction, to out-of-stock medicines and unsanitary restroom conditions. A dedicated team follows up with a phone call to the SMS senders to better assess the situation, and then contacts local authorities who can facilitate immediate solutions.

A separate monitoring component of the programme is also alleviating the once-common problem of absent doctors. The remote, difficult-to-monitor environments of rural Bangladesh create conditions in which doctors could frequently miss work without detection. "Doctors were taking a salary every month, but not [actually] working there," explained Azad. The government responded by setting up a monitoring system that vets physician attendance at 100 of Bangladesh's 800 public hospitals each day. At random, hospitals are asked to join a Skype videoconference call in which doctors must stand in front of the camera to demonstrate their physical presence. Unexcused absences are reported to the MOHFW, which then takes action. Azad noted that these measures have improved the office attendance of doctors by 80–90%. "The patients are now seeing more doctors, and have more time with each of them. They have much higher levels of satisfaction with the service they are receiving."

Citizen Participation in the Health Sector in Rural Bangladesh: Perceptions and Reality

Mahmud, S. 2004. IDS Bulletin, 35.2.

<http://r4d.dfid.gov.uk/PDF/Outputs/CentreOnCitizenship/1052734415-mahmud.2004-citizen.pdf>

This article explores people's perceptions about participation in order to claim the right to health in rural Bangladesh, and the reality of experiences of participation in newly opened spaces for participation within the state health care delivery system – the CGs. This article presents preliminary findings from research into the CGs that sought to explore the enabling and disabling factors for citizen participation in these intermediary spaces for citizen participation in governance.

So far, the effectiveness of the CGs in operating CCs for service delivery to the most disadvantaged groups of the population has been limited, and their ability to function as a space for citizen participation and a means for developing capabilities to participate has been negligible. The CGs have not been able to address the constraints of poverty, dependence on powerful groups, social inequality and invisibility, low self-esteem and lack of interpersonal skills and absence of political clout, all of which prevent citizens from engaging with state institutions in decision-making processes affecting their lives. If anything, these structural constraints have been reproduced and reinforced within the CG, undermining participation within. Hence, citizens' capabilities to participate in governance and accountability of state institutions have not been developed. Neither have the CGs been able to foster a sense of community since perceptions of rich–poor differences in capabilities and citizen responsibility remain very strong.

When interviewees in the case study villages were asked what resources they believed helped in acquiring the capabilities for citizen participation, the two most strongly identified were formal schooling and mobilisation of the poor. People feel that knowledge gained formally through schooling, rather than through less visible non-formal means, allows one to contribute to improving society and influencing public action. Being 'educated in school' is believed to impart status (respect) and social value (especially for girls by their in-laws) and increase visibility. Education is believed to enhance interpersonal skills and reduce exposure to exploitation. Unity and solidarity is highly valued, especially by poor people, since it is believed to generate the strength and power to both confront the lack of accountability of state institutions and deal with the dependence of the poor on the patronage and support of more powerful groups. Being part of a group also reduces the possibility of being identified or singled out and minimises individual costs of participation. It is felt, even by the non-poor, that if poor people are united they can articulate their demands more forcefully.

Evidence suggests that schooling to a certain threshold level can be an important resource to develop capabilities for participation and that group membership can provide a fallback against different kinds of class- and gender-based oppression, creating a social and political space for organising collective action and enhancing individual agency in taking positive actions that improve well-being. In rural Bangladesh, the key

educational factor is access to secondary schooling, which for the poor is severely constrained as a result of direct and indirect costs and the associated pressures to drop out for marriage or to enter the labour market. Access to institutions that promote organisation and mobilisation is relatively greater, and for the poor and women group membership appears to be a promising resource for developing participation capabilities.

What this analysis has shown is that even if structural factors are addressed, fundamental questions of power, hierarchy and exclusion will continue to condition the potential for the emergence of a process of empowerment as both driver and consequence of citizen participation. Investing in education and group solidarity as sources of empowerment are neither easy nor short-term solutions. However, implementing initiatives for community involvement in health such as the CGs without adequate attention to these questions carries the risk of simply reinforcing existing power hierarchies and generating further frustrated expectations among the poor and marginalised.

Incorporation of Community's Voice into Health and Population Sector Programme of Bangladesh for its Transparency and Accountability

Uddin, J., Ashraf, A., Sirajuddin, A.K.M., Alam, M., Tuñón, C. 2001, ICDDR, B Working Paper 148

http://www.icddr.org/what-we-do/publications/doc_download/1002-incorporation-of-communitys-voice-into-health-and-population-sector-programme-of-bangladesh-for-its-transparency-and-accountability-wp148-2001

The study assessed the implementation processes of stakeholder committees, as well as the effects of the committees, especially participation of Essential Services Package (ESP) users in incorporation of community's voice into HPSP to establish transparency and accountability in the programme.

Members of the stakeholder committees themselves developed the terms of reference. Each committee prepared its own workplan. About two-thirds of them had correct knowledge on the purpose of forming the committees and their terms of reference. The male members were more knowledgeable about the terms of reference than the female members. Seventy percent of the members were aware of the major issues outlined in the terms of reference. All the members considered the terms of reference appropriate.

Over 90% of the planned meetings of committees were held with 90% attendance. Ninety-two percent of the committee members reported that they had an equal scope to get themselves involved in the activities of the committees, and the opinions of members were respected. The local health problems dominated the discussions of meetings, and the members made efforts to solve the problems identified. They indicated the usefulness of committees in raising awareness among the rural people about sources of health services and effects of adolescent marriage, assisting in organisation of the National Immunisation Days (NIDs), and removing unauthorised structures from health centre compounds.

The committees regularly monitored the activities of local health centres, resulting in regular attendance and a longer period of stay of service providers, elimination of the practice of charging clients illegally, and serving poor patients with respect.

Most health service users in focus group discussions reported that there were improvements in cleanliness, waiting arrangements, waiting time, and service-providing hours at the health centres after the formation of committees.

About 60% of both male and female members were aware of the HPSP, and half of them could explain the NID. The female members were knowledgeable about the EPI sites as a place for vaccination of children aged under five and tetanus toxoid (TT) for pregnant women and satellite clinics as a place for serving pregnant mothers.

The knowledge about Union Health and Family Welfare Centres was almost equal between the male and the female members. However, knowledge about the Thana Health Complexes was higher among the male members compared to the female members. The female members had low knowledge about CCs compared to the male members. The knowledge of female members about reproductive tract infections (RTIs) was higher compared to the male members. The female members could provide some explanation about RTIs. Seventy-eight percent of the male members and 23% of the female members viewed sexually transmitted diseases (STDs) as a bad disease. The male members had more knowledge than the female members about AIDS as a dreadful disease for which there is no cure and HIV as a germ causing AIDS.

The members of thana committees were more literate than the union committee members. Sixty percent of the thana committee members had higher secondary grade education, while it was 22% among the union committee members. Fourteen percent of the union committee members had no formal education. The

proportion of owners of cultivable land was higher among the union committee members than among the thana committee members. Although there was an equal representation from the poor socioeconomic group and females in both the committees, they were selected mainly from working areas of facilitating NGOs (four NGOs facilitated stakeholder committee activities in intervention areas).

Although there was no major opposition from the service providers, the thana-level managers of MOHFW were reluctant to cooperate with the committees. Some MOHFW managers felt to be disgraceful in monitoring the activities of health centres by the committees. The stakeholder committees did not follow any standard procedures in implementing their activities. Absence of monitoring by the NSC and lack of necessary funds affected implementation of committee activities.

Considering the shorter period of operation of stakeholder committees, it was too early to expect any significant change in terms of quality of services, transparency, and accountability. However, the committees demonstrated their strength in addressing the commonly discussed barriers to quality of care, such as negative attitudes/behaviours of service providers, poor interactions between clients and service providers, and lack of essential drugs and supplies in the facilities. Although it was not possible to assess the level of sensitivity of committee members on gender issues, their efforts to minimise social barriers to acceptance of TT immunisation during pregnancy and the effects of adolescent marriage made a positive impression on committee activities.

In Bangladesh Citizens Leave a Legacy in Health

Mahmud, S. 2009. Citizenship DRC Case Study Series.

http://www.drc-citizenship.org/system/assets/1052734343/original/1052734343-benequista_etal.2009-in.pdf?1288872986

This case study looks at two community health programmes: 1) community-owned and managed health clinics; and 2) Health Watch Committees set up by NGOs. Most of the community-owned clinics were abandoned but some of the committees survived.

New participatory institutions set up by the state can provide opportunities for more inclusive forms of representation, bolster community acceptance and create real pressure for progressive policy change. Research on these particular health institutions in Bangladesh, however, found that unless citizens are politically aware and mobilised prior to participation in these government initiatives, these new spaces for citizen participation can quickly lose their attraction for citizens. The research also found that governments have an interest in ensuring that citizens arrive informed and mobilised. Without these conditions, participatory spaces will fail to provide the legitimacy and efficiency that officials hope to obtain. Furthermore, if these initiatives for public participation are to deliver on their promise of strengthening accountability, they must allow for direct engagement between citizens, public providers and local and state officials.

Research found that the processes of recruitment to the two different initiatives differed significantly. Selection for the management of the clinics was neither transparent nor participatory. Membership was biased towards the better-off and professional classes. The wives of wealthy men were usually selected to fill the spots reserved for women. This bias towards the elite limited its legitimacy among the rest of the community. Selection to Health Watch Committees, in contrast, was fairly transparent and more participatory, conducted through popular voting at an open workshop attended by a range of social classes and affiliates of Nijera Kori.

The selection process had far-reaching consequences for how these organisations have functioned. Social inequalities were still present among the members of the Health Watch Committees, but efforts have been made to overcome them. As one woman said, “I think that we always try to participate equally in the meetings, but there are differences in educational level and status, so there is a difference in people’s ability to think and talk. However, if a member is remarkably silent, then we encourage them to speak up.”

Another striking difference between the two institutions is in their impact on the participants and on service delivery. The community health clinics, most of which soon disappeared, had little positive impact or outcomes, while the Health Watch Committees produced a series of interesting outcomes. At the community level, people have become more aware of what services are available, as evidence by rising numbers of people in those areas seeking maternal health care, immunisation and family planning. Awareness of nutrition, hygiene and sanitation also improved. As one woman member of a health watch committee said, “People are now...conscious about healthcare in general. When people refer to us in the hospital they get

better attention. Now they get medicines more often. And when they don't get proper healthcare and complain to me, then I go to the hospital and speak to the doctors.”

Citizen Participation and Voice in the Health Sector in Bangladesh

Thomas, D. et al. 2003. Options, DFID, phd.

<http://lcbangladesh.org/HealthandPopulation/reports/Final%20report.doc>

This study was initiated at the request of the MOHFW to contribute to the development of the Ministry's stakeholder participation strategy. The study documents the experience of 14 citizen participation and voice initiatives in the health sector, and their achievements and failures in improving the responsiveness of health providers and policy-makers.

The study focuses on the dynamic relationship between citizen voice on the demand side and provider responsiveness on the supply side, as well as the nature and strength of the accountability relationships produced by this dynamic. The four key themes that emerge from the study are: the social constraints to citizen participation and voice; the structural barriers that constrain the influence of voice; the political constraints to citizen participation and voice; and relationships of accountability.

We conclude that significant political and institutional changes will be required to release the bottlenecks on citizen voice and participation so that it can support the GoB's health sector reform agenda. Foremost among these is high-level political commitment. Without stronger political commitment and ownership there is a high risk that efforts by the MOHFW to strengthen and expand citizen participation will result in hollow and superficial initiatives that fail to harness their potential contribution. Second, institutional change – both structural and cultural – is essential to enable the state to respond, and equip the service to engage in citizen participation.

Civil Society Participation in Health Sector Reforms in Bangladesh

International Women's Health Coalition (IWHC) Webpage accessed 30/5/2013

http://www.iwhc.org/index.php?option=com_content&task=view&id=2246&Itemid=540

Following the Cairo conference, which changed population policy and where the GoB played a significant role, IWHC worked on behalf of the Swedish government to redesign Bangladesh's population policy from a conventionally narrow emphasis on family planning services alone to inclusion of essential obstetric care, improved ante-natal services, attention to adolescents and young married couples, and initiation of an HIV/AIDS programme along with other STD services.

Thanks to this coordinated government and civil society initiative, the percentage of women receiving ANC rose from 26% to 56%, female life expectancy increased from 58 to 60 years, and the maternal mortality ratio fell from 440 maternal deaths per 100,000 live births to 322, between 1998 and 2003. The use of emergency obstetric care rose from 5% to 27%, and the mortality rate for children under five in Bangladesh also dropped significantly.

While health indicators for women and girls generally continue to improve, women's and other civil society groups continue to be excluded from policy design and implementation. For example, a draft Health Law was recently created by the government with no input from civil society.

IWHC has worked to build civil society participation in Bangladesh to have a stronger voice in impacting health policy and programming. This continues to be important as donor funding for reproductive health has fallen dramatically in recent years in the country. A 2006 IWHC-supported research project focused attention on the need to involve civil society throughout the reform process. Through documentation, public advocacy, and a series of workshops and dialogues on reproductive health with civil society, village health watch committee members, government officials, researchers, service providers, and the press, the project built local advocacy capacity to hold government accountable.

Researchers affiliated with IWHC's work in Bangladesh established the National Health Watch, which is housed in the BRAC School of Public Health, to ensure implementation of the national health agenda. The Health Watch hosts national meetings bringing together health activists, policy-makers and researchers to address gaps in policy. IWHC has also supported researchers at BRAC to train civil society to integrate a human rights and sexuality approach to their health advocacy.

4. Models of voice and accountability

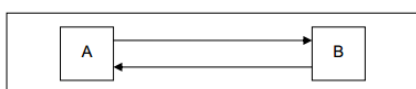
Evaluation of Citizens' Voice and Accountability. Review of the Literature and Donor Approaches Report

O'Neil, T., Foresti, M. & Hudson, A. 2007. DFID.

<http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/237.pdf>

Accountability refers to the nature of a relationship between two parties. A relationship may be characterised as lacking in accountability or highly accountable. In a relationship between two parties, A is accountable to B, if A is obliged to explain and justify her actions to B, and B is able to sanction A if her conduct, or explanation for it, is found to be unsatisfactory. These are the two dimensions of accountability – answerability and enforceability (also called controllability or sanction) – which must exist for there to be real accountability. In addition, both dimensions of accountability require that there is transparency; in the absence of reliable and timely information, there is no basis for demanding answers or for enforcing sanctions.

Figure 1: The accountability relationship: a static model (page 3 of the report)



Beyond the $A \leftrightarrow B$ model of accountability, commentators from different traditions use different vocabularies to talk about the roles within an accountability relationship.

Borrowing from the language of economics, some commentators refer to the demand and supply sides of accountability, with the demanders being those who ask for answers and enforce sanctions. This language is prevalent within the donor community. Alternatively, from a human rights perspective, accountability is about the relationship between a bearer of a right or a legitimate claim and the agents or agencies responsible for fulfilling or respecting that right. A further way of talking about accountability is in terms of an accouter and an accoutee, with the accouter being the agent that demands answers and enforces sanctions.

While voice and accountability are intimately related, they are not the same. Voice is about people expressing their opinions. Accountability is about the relationship between two agents, one of which makes decisions which have an impact on the other and/or which the other has delegated to them. Voice and accountability come together at the point where those exercising voice seek accountability. It is also important to note that voice can strengthen accountability, including by pushing for greater transparency, while accountability can encourage voice by demonstrating that exercising voice can make a difference. In this respect, there is a two-way relationship between voice and accountability.

The landscape of and for voice and accountability is more complex than a simple model of accountability and its relationship to voice suggests. Rather, there are various levels and forms of accountability, and the formal rules of accountability can be in tension with informal rules. In recent years, complexity has increased with the proliferation of actors engaged in accountability struggles, and the emergence of new arenas or jurisdictions for such struggles. In short, voice and accountability are dynamic and complex rather than static and simple; actors play different roles differently, depending on the context.

Voice and Accountability for Improved Service Delivery

UNDP. 2010.

http://www.undp.org/content/rbas/en/home/presscenter/events/2012/November/regional_governance_week/_jcr_content/centerparsys/download_17/file.res/VA_background_paper_final.pdf

The accountability relationships between government, service providers and citizens are complex. The 2004 World Development Report ("Making Services Work for the Poor") provides a useful framework for exploring this complexity. It also offers a way of assessing V&A mechanisms that are appropriate for enhancing V&A in different contexts.

The framework highlights three key sets of actors in the delivery of services:

1. Citizens/clients: individuals and households are simultaneously citizens and clients of services (e.g. healthcare, education, electricity, etc.).

2. Politicians/policy-makers: Politicians are elected or unelected officials who regulate, legislate and tax, while policy-makers implement and enforce these 'rules of the game'.
3. Providers can include public line ministries, departments, agencies or bureaus; autonomous public enterprises; non-profits (e.g. religious schools); or for-profit organisations (e.g. bus companies, private hospitals, etc.). Front-line providers are those who come into direct contact with clients (e.g. teachers, doctors, police, engineers, etc.).

In an ideal situation, these actors are linked in relationships of power and accountability.

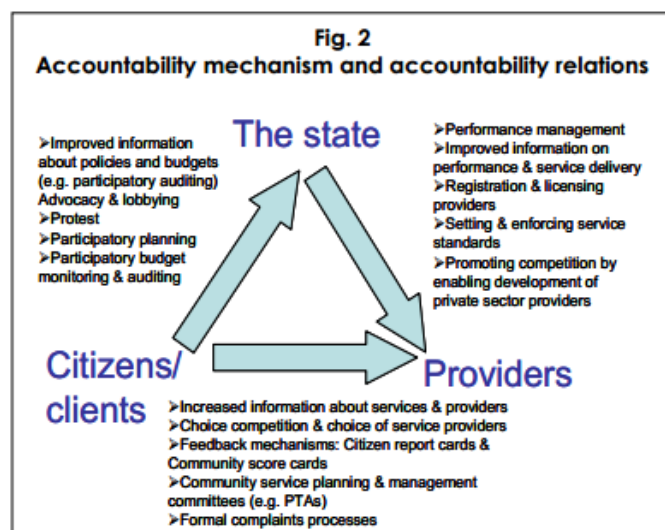


Figure 2 illustrates that different actors can draw on different tools and mechanisms to strengthen the accountability of other actors in this framework. Citizens, for instance, might improve the accountability of service providers by accessing more and better quality information about the quality of services. They might utilise feedback mechanisms such as citizen report cards to comment on the performance of service providers. Citizens can also create user groups and community planning and management committees to engage directly in the planning and monitoring of services.

Accountability and Health Systems: Overview, Framework, and Strategies

Brinkerhoff, D. 2003. Partners for Health Reformplus.

<http://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf>

This paper elaborates a definition of accountability in terms of answerability and sanctions, and distinguishes three types of accountability: financial, performance, and political/democratic. The role of health sector actors in accountability is reviewed. An accountability-mapping tool is proposed that identifies linkages among health sector actors and assesses capacity to demand and supply information.

The paper describes three accountability-enhancing strategies: reducing abuse, assuring compliance with procedures and standards, and improving performance/learning. Using an accountability lens can: a) help to generate a system-wide perspective on health sector reform, and b) identify connections among individual improvement interventions. These results can support synergistic outcomes, enhance system performance, and contribute to sustainability.

Understanding and Improving Accountability in Education: A Conceptual Framework and Guideposts from Three Decentralization Reform Experiences in Latin America

Gershberg, A.I. 2012. World Development, 40 (5).

<http://www.sciencedirect.com/science/article/pii/S0305750X11002981>

Many countries have emphasised hierarchical control or different exit and voice mechanisms to increase accountability of educational systems. This paper builds a framework for understanding accountability reforms and develops three illustrative Latin American cases representing distinct approaches (Chile, Nicaragua, and Bogotá, Colombia). It highlights the complexity of institutional change and the value of

flexible reform models. Using an institutional perspective, the components of accountability, their complex interrelationships, and the importance of design details, implementation, and monitoring are examined. The paper argues for balancing clear and efficient top-down monitoring and enforcement with other, less punitive accountability mechanisms including strong local quality support systems.

Measuring Change and Results in Voice and Accountability Work

Holland, J. & Thirkell, A. with Trepanier, E. & Earle, E. 2009. DFID Working Paper
<https://www1.oecd.org/derec/unitedkingdom/44463612.pdf>

V&A programmes can adopt a very wide range of approaches, and operate in very diverse situations and contexts. This diversity of approach presents challenges for evaluation, since few common methods or models exist. So, while programmes often demonstrate high levels of innovation, there are a lot of inconsistencies in evaluation quality and the type of indicators used.

5. Additional information

Author

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Annex C Reference documents assembled

(In addition to the Annex B references)

Reality Check. 2012 *Reality Check Reflection Report*. SIDA

Bangladesh Health Watch. 2006. *Challenges of Achieving Equity in Health*. Bangladesh Health Watch

CARE Bangladesh. 2011. *Key Elements for Scaling up the Community Support System in Bangladesh*. CARE Bangladesh

JICA. 2012. *Newsletters of the Safe Motherhood Promotion Project Phase 2*. JICA

Bangladesh Health Watch. 2011. *Moving Towards Universal Health Coverage*. Bangladesh Health Watch

Bangladesh Health Watch. 2009. *How Healthy is Health Sector Governance?* Bangladesh Health Watch

Bangladesh Health Watch. 2007. *Health Workforce in Bangladesh – Who Constitutes the Healthcare System?* Bangladesh Health Watch

Bangladesh Health Watch. 2006. *The State of Health in Bangladesh – Challenges of Achieving Equity in Health*. Bangladesh Health Watch

Safe Motherhood Promotion Project. Date unknown. *Narsingdi Model in Bangladesh*. JICA

MOHFW. 2012. *Joint Aide Memoire of Annual Review of HPNSDP*

MOHFW. 2012. *Annual Program Implementation Report*

MOHFW. 2010. *Strategic Plan for Health, Population and Nutrition Sector Development, 2011–2016*

Deborah Thomas. 2003. *Citizen Participation and Voice in the Health Sector in Bangladesh*. DFID

MOHFW. Date unknown. *Community Group Management Guideline*

MOHFW. 2012. *Annual Programme Review HPNSDP – Consolidated Technical Report of IRT, Key Findings, Conclusions and Recommendations*

MOHFW. 2012. *Consolidated APR 2012 Technical Report – Consolidated Annexes*

Unknown Author. Unknown date. *Demand, Equity, Participation, and Accountability Issues*

Reality Check. Reference materials. www.reality-check-approach.com/reality-checks/bangladesh/3-bangladesh

Bangladesh Health Sector Development Project. 2012. *Annex E: Update on Governance and Accountability Plan (GAAP)*.

Good Health at Low Cost Research Team – *Chapters 1,3,8,9,10,11*

- MOHFW. 2012. *Expanding Social Protection for Health; Towards Universal Coverage*
- HDRC. 2012. *Maternal and Neonatal Health Initiative Project Completion Review*. DFID
- MOHFW. 2011. *HPNSDP 2011–2016 Program Implementation Plan Volume 1*
- MOHFW. 2010. *Presentation to National Workshop on Finalisation of Community Group Management Guideline*
- Shamsuddin Ahmad. Undated. *Presentation: Urban Health Care in Bangladesh: A Challenge*
- Y Kamiya, Y Yoshimura, MT Islam. 2013. *An impact evaluation of the Safe Motherhood Promotion Project in Bangladesh*. Social Science and Medicine
- NIPORT. 2010. *Utilisation of Essential Service Delivery Survey 2010 (Provisional Findings)*

We also consulted a number of newsletters, flyers and the like.

Annex D Persons met

Name	Designation and organisation
Dr Jahangir Hossain	Programme Director-Health, CARE
Md Khairul Alam	Project Coordinator, Community Mobilisation, CARE
Md Ahsanul Islam	Team Leader, MNH Programme, CARE
Zahirul Islam	Programme Officer-Health, SIDA
Yann Borick	AUSAID
Ellan Forth	Dutch Embassy
Mira Mitra	Focal Point for Gender, UNICEF
Carolina	SIDA
Bushra Ahmed	Senior Health Specialist, World Bank
Khaled Hossain	World Bank
Jacqueline T F Mahon	Senior Economist (Health, Nutrition and Population) World Bank
Yukie Yoshimura	Chief Advisor, JICA
Dr Musa	Line Director, Primary Health Care, DGHS
Dr Katamaya	WHO
Naved Ahmed Chowdhury	Social Development Adviser, DFID
Tahmid Ahmed	Professor of Nutrition, icddr,b
Sabrina Ahmed	Centre of Equity, icddr,b
Dr Tanvir Huda	icddr,b
Peter Kim Streatfield	Director, Centre for Population, Urbanisation and Climate Change, icddr,b
Dr Asib Nasim	UNICEF
Mr Sharif	Population Council
Dr Sabur	UNICEF
Ladly K Faiz	Chief Executive, Population, Research and Development Associates
Dr Atahar Ahmed	Eminence
Mrs Sanjida	Engender Health
Selina Amin	Country Projects Manager, Plan Bangladesh
Sharif Mahbubul Kuddus	Project Manager, CC, Plan Bangladesh
Mr Dukul Barua	District Manager, JICA
Dr Md Shafiqul Islam	UHFPO, Narshingdi UHC
Saydul Alam	Elected Member of Union Council and Convener, CSG, Narshingdi
Md Billal Miah	Health Inspector, UHC, Narshingdi
Salma Begum	Assistant Health Inspector, UHC, Narshingdi
Mr Mostafa	Former Union Council Chairman, Narshingdi
Md Ali	Family Planning Inspector, UHC, Narshingdi
Md Nazimuddin	Joint Convener, CSG, Narshingdi
Shahana Begum	Joint Convener, CSG, Narshingdi
Tahmina	Member, CSG, Narshingdi
Nilufer Akter	CHCP, Narshingdi
Asims Khatun	Member, CSG, Narshingdi
Rehana Begum	Member, CSG, Narshingdi
Md Hossain Bhuiys	Union Council Chairman, Musapur, Narshingdi
Fatema Akter	CHCP, Khaglabazar, Narshingdi
Maya Rani Das	FWA, Ward 1, Musapur Union
Shahnaz Momtaz	FWA, Musapur Union
Abu Syed	Secretary, CC
Waliul Islam	Member, CSG
Dr Shafiqul Alam	UHFPO, Narshingdi

Dr Shujit Paul	Medical Officer, UHC, Narshingdi
Dr Nitai Das	Director, PSTC
Md Arif Hossain Khan	Programme Manager, MJF
Shaheen Kausar	Deputy Programme Manager, MJF
Shamanando P Chowdhury	Coordinator, Programme, PSTC
Md Masum Kabir	Programme Officer, PSTC
Jahanul Haque Babul	Area Coordinator, MJF, Narshingdi
Mahshiul Goni Shopon	Chairman, Union Council, Narshingdi
Mr Selim	Student Leader, Member of CA, Narshingdi
Shahnaz Ferdousi	Union Council Member, Narshingdi
Mahtab Uddin	Union Council Member, Narshingdi
Mr Mamun	General Secretary, CA, Narshingdi
Abul Kader Sarker	Advocate and Member of CA, Narshingdi
Faruq Molla	Vice Chairman, Upazila Council and member, CA, Narshingdi
Amzad Hossain	Secretary, CA, Narshingdi
Zahiruddin	General Secretary, CA, Narshingdi
Mostafa Kamal	Coordinator, CA, Narshingdi
Moniruzzaman	CA Member/Organiser, Narshingdi
Nargis Begum	FWV, UHFWC, Morjal, Narshingdi
Rawshan Ara	SACMO, UHFWC, Morjal, Narshingdi
Md Abdul Hanif	Pharmacist, UHFWC, Morjal, Narshingdi
Anwara Begum	Family Welfare Assistant, UHFWC, Morjal, Narshingdi
Helena Begum	Family Welfare Assistant, UHFWC, Morjal, Narshingdi
Fatema Jannat	Union Council Member, Morjal, Narshingdi
Selina Akhter	Union Council Member, Morjal, Narshingdi
Md Rabiullah	Chairman, Union Council, Morjal, Narshingdi
Khairuzzaman Manik	Community Development Manager, CARE, Tala Upazila, Satkhira
Humayun Kabir	Community Mobiliser, CARE, Tala Upazila, Satkhira
Dr A S M Zahirul Hassan	UHFPO, Tala Upazila, Satkhira
Sheikh Akkas Ali	Secretary, Hazrakathi CG, Tala Upazila, Satkhira
Jalilur Rahman	Assistant Health Inspector, UHC, Tala Upazila, Satkhira
Md Mahbubur Rahman	UNO, Tala Upazila, Satkhira
S M Nazrul Islam	Union Council Chairman, Tala Upazila, Satkhira
Kapana Biswash	Member, Hazrakathi CG, Tala Upazila, Satkhira
Riazuddin	Member, Hazrakathi CG, Tala Upazila, Satkhira
Ahmad Ali	Member, Hazrakathi CG, Tala Upazila, Satkhira
Aziz Mohammad	Member, Hazrakathi CG, Tala Upazila, Satkhira
Shamsunnahar	Family Welfare Assistant, UHFWC, Tala Upazila, Satkhira
Momtaz	Member, Hazrakathi CG, Tala Upazila, Satkhira
Meherun Islam	Member, Hazrakathi CG, Tala Upazila, Satkhira
Shafiqul Islam	CHCP, Hazrakathi CC, Tala Upazila, Satkhira
Baharul	Member, Hazrakathi CG, Tala Upazila, Satkhira
Suma Sarkar	Member Secretary, Uttar Atai CSG, Tala Upazila, Satkhira
Dipon Sarker	Treasurer, Uttar Atai CSG, Tala Upazila, Satkhira
Shikha	Joint Secretary, Uttar Atai CSG, Tala Upazila, Satkhira
Bashonti	Member, Uttar Atai CSG, Tala Upazila, Satkhira
Apurba Roy	Member, Uttar Atai CSG, Tala Upazila, Satkhira
Tripod Das	Member, Uttar Atai CSG, Tala Upazila, Satkhira
Shri Panchanam Das	Member, Uttar Atai CSG, Tala Upazila, Satkhira
Rashid Gazi	Member, Uttar Atai CSG, Tala Upazila, Satkhira
Dhiraj Nath	Asian Development Bank
Ms Makduma Nargis	Line Director, Revitalisation of CCs

Name	Designation
Dr Zafarullah Chowdhury	Member, Board of Trusty, Gana Sashthyo Kendro
Monjur Kader Ahmed	Coordinator, Gana Sashthyo Kendro
Syed Khaled Ahsan	Public Sector Specialist, The World Bank
Samia Afrin	Project Manager, Naripokho
Health Reporters Forum	
Sishir Moral	The Daily Prothom Alo
Toufiq Maruf	The Daily Kaler Kontho
Hamid Ul Kabir	The Daily Naya Digonto
Nurul Islam	Bdnews24. com
TIB Modhupur	
Dr Nurul Huda	UHFPO, Modhupur UHC
Dr Shafiqul Islam	RMO, Modhupur UHC
Dr Rokonuzzaman	MO, Modhupur UHC
Dr Nuruzzaman	Orthopedic Surgeon, Modhupur UHC
Dr Forhad Alam Moni	ViceChairman, Modhupur Upazila Council
Shri Kumer Guho Neogi	Chairman, CCC
Shunil Kumar Mojumder	Member, CCC
Jaedul Islam	YES member
Tanvir Ahmed	YES member
Habibur Rahman	Area Manager, TIB
Md Reaz Uddin Khan	Senior Programme Manager, TIB
TIB Jamalpur	
Dr Md Alomgir Hossain	Field District Officer, UNFPA
Md Alauddin Abu Tahid	PFAO, MNH Initiative, UNFPA
Shamima Khan	ED, Taranga Mohila Kallyan Sanghtha, Jamalpur
Sufia Hoque	Member, District Health Service User Forum
Md Muklesur Rahman	Member Secretary, District Health Service User Forum
Ferdous Ara Mahmuda	Member, CCC
Uma Chowdhury	Director, Civic Engagement
Yasmin Ara	Deputy Programme Manager, TIB
Farid Ahmed	YES member
Rupal Saha	YES member
Saiful Mustofa	YES member
Fazley Rabbi and others	YES member
Marzia Begum	Vice President, CCC
Md Momtaz Uddin	Vice President, CCC
Monowara Begum	Member, CCC
Momataz Akter Khatun and others	Member, CCC
Md Jahangir Hossen Khan	President, Rajabani Union Sreepur Gazipur
Mrs Afroza	Member, Secretary
Md Abdul Alim	Member, Freedim Fighter
Onita Rani Dash	AHI, Gazaria CC
Afroza	CHCP, Gazaria, CC
Briggem MD Fashir	Director, CCC, Mymensingh Sadar, MMCH
Emadul Islam	APM (Rsp), TIB