Universal health coverage and community engagement in Bangladesh: a situation analysis

BRAC JAMES P GRANT SCHOOL OF PUBLIC HEALTH

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South-East Asia Region

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Contents

Abstract

Universal health coverage (UHC), a global health agenda, has been ratified by most countries, including Bangladesh. It is well acknowledged that community engagement is a necessary prerequisite for implementing UHC. As Bangladesh moves to achieving UHC by 2030, it is imperative to understand the current level of engagement of its citizens in planning, implementing and monitoring its health programmes and services. This study explored the current level in a local and a national situation analysis. It found a laudable level of citizen participation at local levels: community clinics, union health and family welfare centres and *upazila* health complexes. There is, however, no formal requirement to ensure participation at national level, although ad-hoc attempts to seek citizens' opinions on specific issues, such as formulation of 5-year plans, are not uncommon. Community engagement at national level is often initiated by nongovernmental entities and think tanks. The report analyses the current situation and provides some recommendations for enhancing the participation of citizens in the health sector in Bangladesh.

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Abbreviations

BHW	Bangladesh Health Watch
CC	community clinic
CG	community group
CHCP	community health care provider
CSG	community support group
FWA	family welfare assistant
HA	health assistant
MoHFW	Ministry of Health and Family Welfare
MP	Member of Parliament
NGO	nongovernmental organization
PHC	primary health care
UHC	universal health coverage

A1.1 Introduction

Achievement of universal health coverage (UHC) has been ratified by most countries, including Bangladesh. UHC refers to organized health-care systems in which "all people have access to essential health services without the financial hardship associated with payment" *(1)*. According to WHO *(2),* UHC refers to "access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable price". In other words, UHC is achieved when every citizen can access the health services they need without suffering financial hardship *(3)*. UHC is an important target (3.8) of the United Nations Sustainable Development Goals. The Government of Bangladesh is exploring policy options to increase fiscal space for health to extend coverage and improve the quality and availability of services, although these remain challenges *(4)*. While ensuring access to health services and providing financial protection to everyone are essential for UHC, it is important to recognize the critical role of people themselves and their organizations in achieving that goal. Globally, health-care expenses push 25 million households each year into abject poverty. It is estimated that, in Bangladesh alone, catastrophic health expenditure results in 5.7 million Bangladeshis being pushed into poverty *(5)*.

Community engagement refers to deliberate inclusion of communities in designing and implementing health programmes, to "involve them and their advocates as partners rather than merely subjects, or eventual users of the intervention" *(6)*. Community engagement can change behaviour, environments, policies, programmes and practices *(7)*. Community engagement consists not merely of taking health services to the community but "in and with" the community.

A1.1.1 UHC and community engagement

Community engagement is a necessary prerequisite for implementing UHC. Over the past two decades, much has been written about UHC. UHC has sometimes been siloed into financial arrangements alone, "without considering the importance of social determinants of health and of community involvement" *(8)*. The situation is, however, improving, with increased attention to the quality of services.

According to the Alma Ata Declaration of 1978 *(9)*, effective community engagement is a fundamental component of an efficient, equitable PHC system to address the needs of diverse populations. Achievement of health goals requires people's direct engagement in planning, implementing and monitoring health-care programmes. Community engagement is an important pillar of any effective health-care programme. The coronavirus disease 2019 (COVID-19) pandemic (and, previously, HIV/AIDS and Ebola virus disease) has highlighted once again the critical role of community engagement in preventing and managing crises and the need for collective action. Marston et al. *(10)* outlined a three-step solution for effective involvement of the people:

> ensuring that the needs of the most vulnerable groups in society are also well-reflected in health policy making. Developing a participatory health system culture supported by systematic engagement between governments and civil society and communities prior to the onset of crisis is central to building preparedness and resilience. Once the shock strikes, these participatory mechanisms can then be leveraged for a coordinated whole-of-society emergency response.

Bangladesh has a chequered history of community involvement in planning, implementing and monitoring in the health sector. Involvement is significantly high during natural calamities, such as

floods and cyclones, and was at its peak during campaigns to provide oral rehydration therapy and vaccination in the 1980s and 1990s *(11,12)*. A foundation for people's participation in designing and implementing policies and services that affected them directly them was the Local Initiatives Programme, implemented in 1987 by the Government, with support from the United States Agency for International Development, to ensure sustainable family planning and maternal and child health services at local levels. The basis of the project was integration of local government officials, service providers, community leaders and citizens in managing and participating in the design and conduct of their own programmes *(13)*. The Project was considered successful[1] at the time and was meant to serve as a pilot model to be replicated in other areas of the country to create a sustainable system of governance in which local government institutions facilitate and implement national priorities at community level with limited assistance. The programme was phased out but laid the grounds for the current approach to a participatory system of governance.

Bangladesh has one of the densest public health infrastructures in South Asia. In addition to teaching and tertiary care hospitals, it has about 500 *upazila* health complexes, around 5000 union[2] subcentres and nearly 14 000 community clinics (CCs). There is a dearth of trained health-care professionals and qualified workers, particularly in rural areas, with inadequate availability of drugs and other essential supplies, poor budgetary allocations (receiving only a fourth of the health budget[3]), lack of accountability, mismanagement and poor governance. PHC in Bangladesh is thus grossly neglected.

As in many other countries, the ongoing pandemic has exposed the vulnerability of the health system *(14)*. It has also provided an opportunity to reconsider our approach to health care and, broadly, UHC. What has been achieved in socioeconomic development in the past 50 years as an independent nation is the envy of many. While we celebrate it, we should not be complacent. Establishment of UHC is a sine qua non for ensuring the kind of health services that the citizens of Bangladesh deserve. In addition to community engagement to support delivery of health services, movement towards a participatory governance culture, with systematic, ongoing engagement is necessary for UHC and for resilience and equitable health outcomes.

A1.1.2 Research objectives

The aim of this study was to understand means for integrating community engagement into the UHC movement in Bangladesh. In so doing, the research also identified the constraints for engaging citizens at community and at national governance and policy levels. We explored new mechanisms, platforms and processes for community engagement that have been initiated since the onset of COVID-19. We also analysed the socio-political, economic and structural factors that facilitate or hinder community engagement.

1 The Project served 2.35 million eligible couples and 1.52 million contraceptive users in 645 unions in 104 *upazilas*, covering approximately one fourth of all *upazilas* in the country. They formed partnerships with family planning staff, local leaders and Government health administrators by setting up "*thana* teams" and engaged community members and local women by involving them in committees that oversaw the quality of service delivery or by directly involving them in voluntary service delivery *(13)*.

2 Population unit formed by several villages as a collective

3 Thailand, which has an effective health system, spends 40% of its budget on PHC. (See Annex 3 of this publication.)

The specific objectives of the study were to:

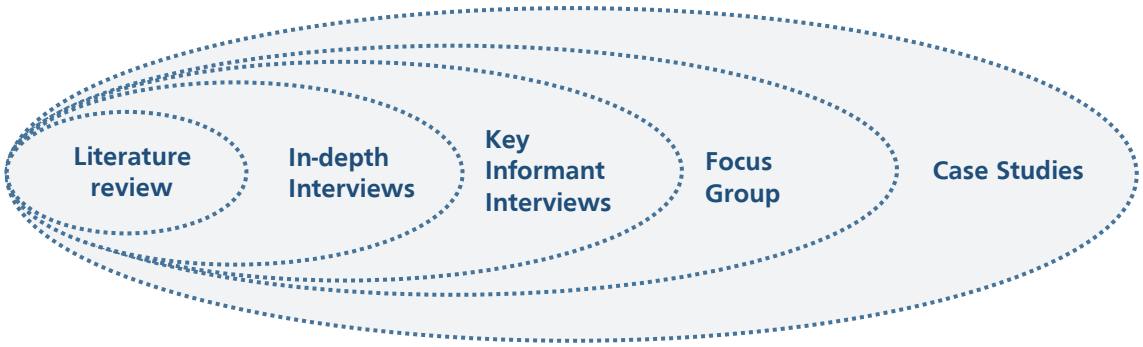
- review existing platforms, mechanisms and processes for community engagement in strategy development and planning and assess their effectiveness from the perspectives of
  - health service users and communities and
  - policy-makers;
- identify any new mechanisms, platforms and processes for community engagement initiated since the onset of the pandemic;
- analyse the social, political, economic and institutional factors that facilitate or hinder meaningful community engagement; and
- identify lessons learnt for moving towards a more participatory governance approach through systematic, ongoing engagement.

A1.2 Methods

Qualitative research methods were used to address the objectives, in four stages (Fig. A1.1):

- an extensive review of published and grey literature to identify existing platforms for community engagement in strategy development, planning and monitoring from the perspectives of both communities and policy-makers;
- exploration of new mechanisms, platforms and processes for community engagement initiated since the onset of the pandemic through in-depth interviews, focus group discussions and key informant interviews;
- identification of the social, political, economic and institutional factors that facilitate or hinder meaningful community engagement, with research tools such as in-depth interviews, focus group discussions, key informant interviews and case studies; and
- analysis of the collected data to meet the stated objectives.

Fig. A1.1. Method used



Fieldwork for the study began in November 2022 and continued until the end of January 2023. We received ethical clearance for all the researchers involved and the approval of the Institutional Review Board to conduct the study.

Two districts, Kurigram and Sunamganj, were selected for the study. Kurigram, located in northern Bangladesh, is in the Rangpur division, with several rivers flowing through it. It consists of 9 *upazilas*, 72 unions and 1872 villages. Sunamganj district is located in north-eastern Bangladesh in the Sylhet division. It comprises 11 *upazilas*, 87 unions and 2887 villages. According to the Bangladesh national census in 2022, Kurigram had a recorded population of 2 329 161, and Sunamganj had a population of 2 695 495. The districts are two of the most vulnerable areas in the country due to the formation of *chars*[4] and *haors*[5]. *Chars* and *haors* form temporary settlements, which are generally cut off from the mainland and can be accessed only by boat during the monsoon, when the river rises. During dry seasons, the only mode of transport is by foot or in carts. These hard-to-reach geographical locations complicate delivery of PHC, let alone access to secondary care, and pose challenges for ensuring citizens' participation.

The two areas were chosen to obtain an overarching view, in view of constraints and limitations on time and resources. Logistical support is crucial for any successful research, and Bangladesh Health Watch (BHW), hosted by the BRAC School of Public Health, provided essential support for access, ensuring that we could cover more ground in a shorter time. As the aim of the study was to explore community engagement at national level, interviews were conducted at that level.

A research team of four was formed, all of whom conducted data collection, in-depth interviews, focus group discussions, key informant interviews and case studies in the field. All the data collected were recorded both on digitally and on paper. Participants gave written consent before each interview on forms that explicitly stated that participation was voluntary and explaining the purpose of the study. Open-ended checklists were prepared for groups of participants, and an observation checklist was available for CC visits (see Appendix A1.1).

National key informants (Government and nongovernmental stakeholders) were interviewed in Dhaka. Key informants in Kurigram and Sunamganj were purposively selected according to their designation, affiliation, responsibilities and potential to provide input for the research. A list of key informants and other participants interviewed for the research is provided in Appendix A1.1. Table A1.1 lists the numbers of interviews conducted in the three locations. Some of the interviews are illustrated in the photographs below.

Table A1.1. Numbers and types of interviews conducted for the study, by location

Type of interview	Kurigram	Sunamganj	Dhaka
In-depth	8	8	
Key informant	5	5	12
Focus group discussion	4	5	
Total	17	18	12

4 *Chars* are ridges of land surrounded by rivers, generally formed by a river breaking and surrounding the underlying soil.

5 A *haor* is a wetland ecosystem, also known as a backswamp, found in northeastern Bangladesh.

Selected photographs from interviews conducted at different study sites

Interview with national health veterans, the senior experts who contributed nationally in the health sector (i.e. medical doctors, public health specialists, bureaucrats, social scientists, etc.), in Dhaka, 2023

Interview with a CC beneficiary, Kurigram, 2022

Interview with the COVID-19 Coordination Committee, in Sunamganj, 2022

Limitations of the study

The study covered two hard-to-reach areas, Kurigram and Sunamganj, in order to investigate the complexities of delivering health care in such regions and the challenge of citizen engagement. Key informant interviews were conducted in the capital, Dhaka, to ensure comprehensive understanding of policy and decision-making and their implementation. Bangladesh has a diverse geography and ecology, with various challenges at each location. A broader set of locations would have provided greater insight into the frailities of the health-care system and better representation of the situation. Maximization of the time available was, however, an important factor, although this constrained the scope for exploring other realities and further elaboration of certain nuanced aspects.

Kurigram and Sunamganj have *char* (river islands) and *haor* (wetland) areas that are extremely difficult to reach, especially in the dry season, with no or little transport. They are also the areas that are most deprived in terms of the availability of PHC. Because of the time constraints, these areas could not be explored to the fullest extent.

A1.3 A short review of the literature

A1.3.1 Background of the public health system in Bangladesh

When Bangladesh became independent in 1971, its health system consisted of eight medical college hospitals, 19 district hospitals, urban and rural health centres and other facilities. From the start, overpopulation was a problem. Thus, a family planning department was created within the Health Department, and, in 1975, two wings of the Ministry of Health were formed, under the newly named Ministry of Health and Population Control *(15)*.

A 5-year plan 1972–1978 was implemented and then extended until 1980. In accordance with the Alma Ata Declaration of 1978 *(9)*, the 5-year plan emphasized PHC. The Government launched a number of child health initiatives during the third and fourth plan periods (1986–1998), including a comprehensive programme on immunization, control of diarrhoeal diseases, control of acute respiratory tract infections, and a night blindness prevention programme *(16)*. These initiatives contributed greatly to reducing mortality and morbidity and increasing life expectancy.

In 2020, Vaughan et al. *(17)* noted that major institutional reforms of the health sector had been implemented with support from external donors in the late 1990s to promote greater equity and resource efficiency. The World Bank and other consortium members had informed the Government in 1996 that they would lend no more money until a comprehensive strategy was in place *(17)*. The Health and Family Office consequently underwent significant structural and organizational transformation, and the Population and Health Sector Strategy established a new course for cost control and efficiency. Although efficiency in the health sector was established through institutional and Government reforms, this strategy was the foundation of the national health policy adopted in 2000 and the fifth 5-year plan, which advocated a common set of institutional reform strategies *(18)*. The strategies include an essential services package, the comprehensive sector-wide approach, unique services provided by CCs at village level, merging of the health and family planning wings, administrative decentralization and establishment of CCs.

Additionally, the Urban Primary Health Care Service Delivery Project was implemented to improve the health of urban residents, particularly the poor, and to extend access to essential services that

were effective, sustainable and affordable. The Project also offers a free essential services package to low-income individuals that gives them access to comprehensive reproductive health centres and primary health centres according to their medical requirements. Usually managed and operated by 12 NGO partners, these centres provide services such as child health, infectious disease control, limited treatment management, infection prevention and control, sexual and reproductive health, primary ophthalmology, free private HIV/AIDS counselling and testing, services for violence against women, tuberculosis control and treatment, behaviour modification, communication and diagnostic services.

The Ministry of Health and Family Welfare (MoHFW) has complete control over the health system in Bangladesh, and health planning is the responsibility of the national Government. Although some decision-making authority has been delegated to local levels, senior officials based in Dhaka still hold the most power. As Miah *(19)* noted, Parliament formally approved the National Health Policy in 2000. Its main objectives were to improve maternal and child health, strengthen family planning services and provide basic health services to all, especially the poor. The policy has been revised several times since its adoption, the last being in 2020. It emphasizes primary and rural health and introduced new issues such as a health insurance system for formal institutions and the provision of health cards. Nevertheless, the policy has not changed much over time.

Islam et al. *(16)* reported that Bangladesh implemented a series of measures, including economic stimulus measures, to stop the spread of COVID-19 during the pandemic. These policies, which resulted in lifestyle changes, include mobility restrictions, wearing of face masks, social isolation and changes in hygiene practices. The Bangladesh Preparedness and Response Plan for COVID-19 was launched by the MoHFW to control and prevent the spread of the disease. In addition, the Government provided safety measures, medical equipment and personal protective equipment to front-line workers and health workers, hired and trained 2000 new doctors and 5000 nurses, increased the number of intensive care units and provided relief supplies for COVID-19 patients and medical supply professionals.

A1.3.2 Structure of the health-care system in Bangladesh

The Constitution of Bangladesh, Article 15 (a), specifies State policy to ensure "the provision of the basic necessities of life, including food, clothing, shelter, education and medical care" to the people. Article 18 (1) states the obligation of the State to increase the level of nutrition and improve public health as part of their primary duties. These principles are, however, not legally enforceable due to limited State capacity. Thus, although they are constitutionally mandated, efforts to improve health services have been shared substantially with the country's private sector, and, despite State efforts, there continue to be significant gaps in the structure.

According to a health system review, the MoHFW retains primary control, as illustrated in the Rules of Business, Schedule 1, and acts as

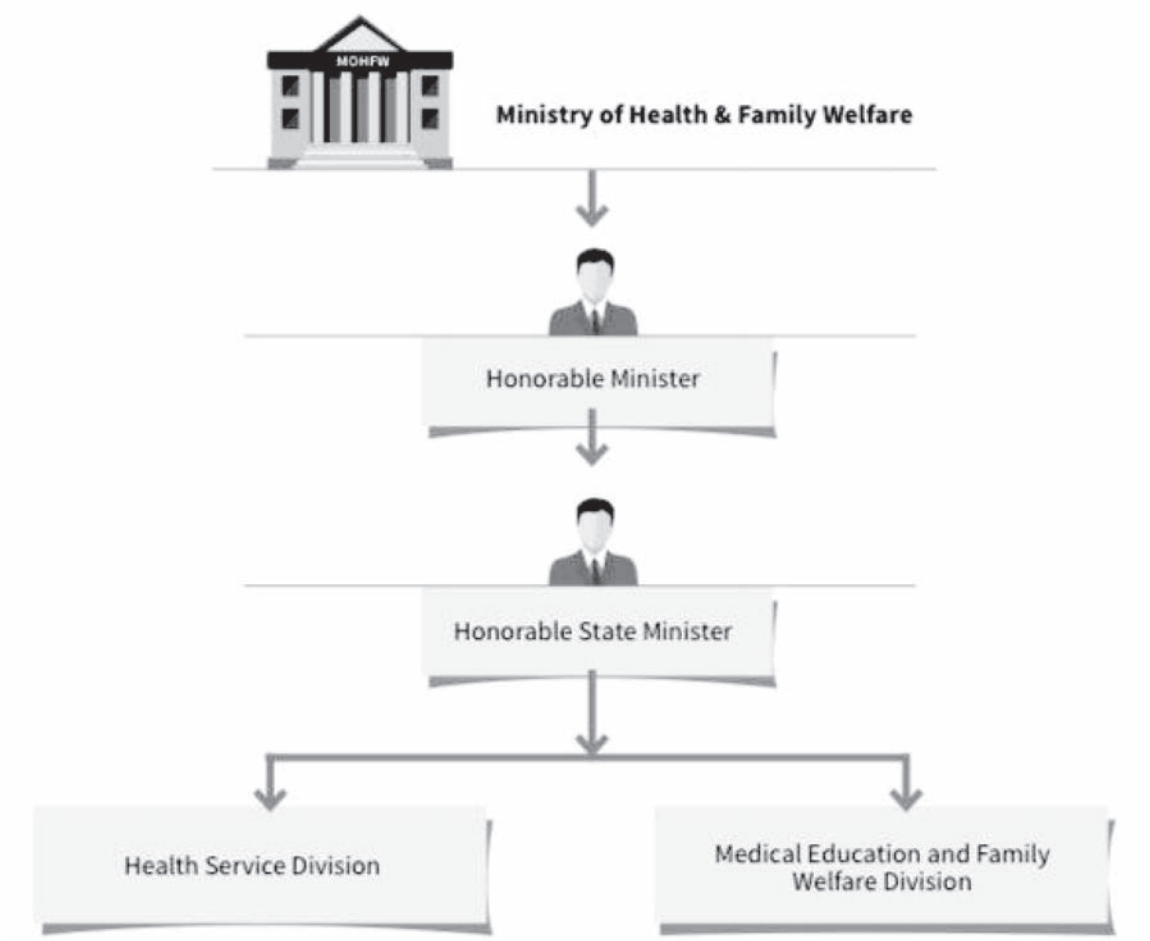
> the central body for policy formulation and planning, regulating the medical profession and standards, managing and controlling drug supply, administering medical institutions, providing health services and more *(15)*.

The report also states that the Ministry and its health and family planning branches oversee public health services ranging from primary to tertiary care, from the top down, in both rural and urban areas, with the exception of urban primary care. In urban areas, the Ministry governs only "institution-based health-care delivery", as PHC is largely in the hands of local government entities

such as city corporations and municipalities, which are a part of the Ministry of Local Government, Rural Development and Cooperatives.

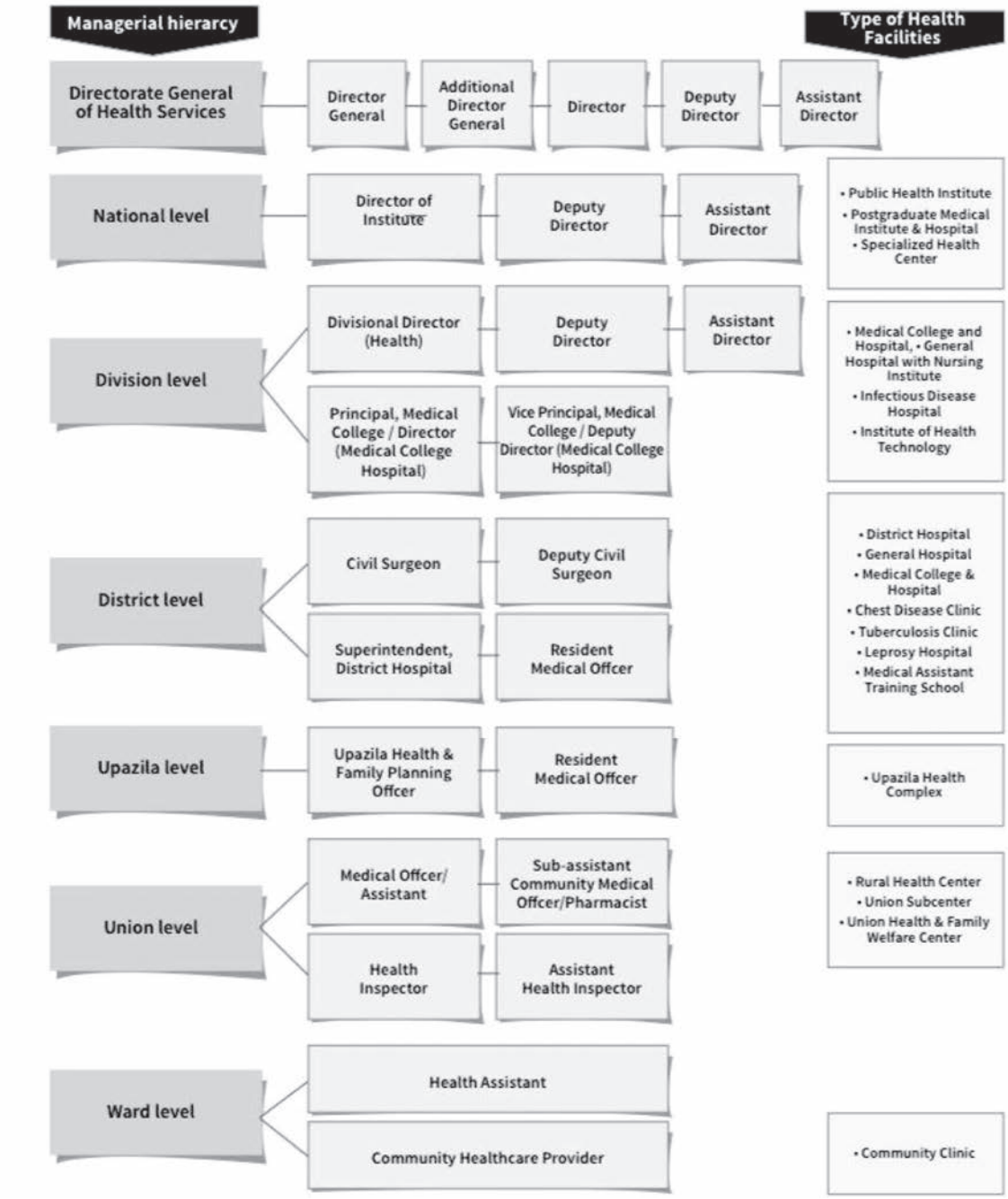
The MoHFW has a dense infrastructure. Service delivery is administrative and top–down: national to district to *upazila* and then to union and ward levels *(15)*. Local governments maintain enough authority to raise concerns and issues at central level but cannot make formal decisions. Instead, their primary purpose is to motivate, endorse and facilitate service delivery. Inefficient financial management results from the dependence of local government agencies on central Government funding. The division of the MoHFW and the managerial hierarchy according to type of facility, from national to ward level, are shown in figures A1.2 and A1.3, respectively.

Fig. A1.2. Divisions of the Ministry of Health and Family Welfare



Source: Management Information System, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of Bangladesh, Dhaka, Health Bulletin (2018).

Fig. A1.3. Managerial hierarchy according to type of facility, from national to ward level



Source: Management Information System, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of Bangladesh, Dhaka, Health Bulletin (2018).

Chaudhury & Hammer *(20)* identified two problems in rural health care, one of which is the reluctance of health-care professionals to live in remote areas and a preference for financial gain by using their highly marketable skills. Despite numerous Government initiatives to ensure that people, especially the rural population, receive PHC, by appointing service providers and staff according to their roles and responsibilities, positions in remote locations remain vacant. PHC in rural areas has thus been grossly neglected and has substantially deteriorated due to geographical disparities in the

distribution of qualified doctors and health facilities. Miah (*19)* reported that CCs, designed to provide PHC through active community participation, include community groups (CGs) and community support groups (CSGs), which help to manage CCs and conduct various awareness-raising activities in hard-to-reach areas. The clinics have 33 types of medicine to treat common and long-standing illnesses. Many patients, however, lack access to primary care due to factors such as distance and access to services and medication. Service providers in CCs appear to be unaware of their responsibilities to improve service. They are also poorly monitored and supervised.

Curative, preventive and promotional health services are not given enough priority in CCs. Community health-care providers (CHCPs), one each in a CC, are the heart of the CCs. There is, however, poor coordination among CHCPs, health assistants (HAs) and family welfare assistants (FWAs) in CCs. According to the director of a health, nutrition and population programme of a large NGO: "the CHCP, HA and the FWA come from three different wings of the government and in most cases, do not prefer talking to each other". Although HAs and FWAs are required to provide support and assistance 3–4 days a week, differences in supervisory authority mean that they are not punctual and there are lapses. It is a challenge for CHCPs to provide the desired services without proper support from HAs and FWAs, who are employees of the MoHFW. They are meant to fill in for the CHCP when he or she is unable to work due to training, administrative work or unavoidable circumstances (e.g. pregnancy or sickness). This is not, however, always the case, and CCs often remain closed when CHCPs are unavailable, further limiting service delivery at clinics.

CSGs, consisting of 13–17 individuals, were planned to provide support for CGs, with 12–15 members, who then – ideally – support the clinic (see below). Their responsibilities include improving community health, bridging the gap between recipients and providers and collaborating on a number of community hospital management initiatives. Although formed as necessary components, research has shown that these groups have been ineffective *(19)*. The possible causes of the ineffectiveness of such committees are discussed below.

A1.4 Brief overview of platforms for community engagement

The main means for institutionalizing people's engagement in health service delivery has been through CCs. When the Government sought to offer an essential services package to vulnerable groups under the 5-year plan of 1998–2003, they changed the service delivery model from house-to-house visits to a fixed-structure service delivery mechanism, and CCs were created to bring vital community health services closer to the people *(21)*. The Government mandated that every CC be governed by a CG and supported by three CSGs to ensure community involvement in the public health sector: giving people a voice in the design, implementation and monitoring of health services.

The smallest unit of a population is the village, or *gram*. At this level, health care is provided by mobile satellite clinics, with advocacy to raise awareness about immunization, health, family planning and the services to which they are entitled to at health and family welfare centres. The mobile satellite clinics also allow open dialogue, especially in hard-to-reach areas, through what is known as *uthan boithok*[6] (courtyard meetings), conducted by FWAs.

6 *Uthan boithok*: a meeting or an open discussion with rural populations for advocacy. The meetings often take place in an open field or courtyard (*uthan*).

In every union, there are a number of CCs – one constructed for every 6000 people, with nearly 14 000 clinics nationwide. These are the lowest tier of health care, second only to satellite clinics. They are run by a local CHCP, with a part-time HA and a FWA for support.[7] Each CC has a CG with 17 members and is led by an elected union *parishad* member.[8] It also has three CSGs, with 35 members each. Creation of the CGs was an initiative of the Government to encourage local involvement and improve governance. The wide criteria for selecting local people were an attempt to create greater representation to incite ownership among different citizens groups to ensure that CCs ran smoothly, i.e. were effective in providing the services for which they were established and to ensure that small decisions, especially in terms of maintenance, could be readily executed with the support of these groups. Tables A1.2 and A1.3 show the composition of such groups.

Table A1.2. CG membership structure for CCs

Post held	No.	Selection procedure	Remarks
Chairperson	1	Union *parishad* member of the CC	One of these three members must be female. The land donor or representative will be the only lifetime member.
Co-Chairperson	2	One land donor or nominated representative and one selected from among members	
Treasurer	1		
Member secretary	1	Community health-care provider, non-voting member	Will provide all kinds of official support to the CG.
Observer	11–13	Selected from among beneficiaries	Non-voting member
Total	15–16		

Source: Ministry of Health and Family Welfare, Health Economics Unit; 2012

Table A1.3. CSG membership structure for CCs

Post held	No.	Remarks
Convener	1	One of the conveners should be female.
Joint convener	2	
Member secretary	1	
Executive member	9–11	
Total	13–15	

Source: Ministry of Health and Family Welfare, Health Economics Unit (2012)

All the CCs are outreach sites for routine immunization and national immunization days. In addition, they provide limited curative care (for minor ailments), screening for hypertension and diabetes and identifying emergency and complicated cases for referral to facilities at *upazila* level *(23)*.

7 HAs are staff of the Health Services Division, and FWAs are staff of the Family Planning Division of the MoHFW. There is a historical rivalry and hostility between the two wings (now divisions) of the MoHFW ever since they were established *(22)*.

8 The union *parishad* or union council is the smallest rural administrative and local government unit.

CCs are run through a trust funded by the government and development partners and through the private sector and with individual donations *(24)*. They are based on a public–private partnership model, whereby the land for the facility is donated by a local resident. The donor receives lifetime membership of the respective CC and the title of Senior Vice-President. A study in 2017 showed that awareness about CCs among women was about 36% *(25)*.

At the Union level, a Union health and family welfare centre management committee is headed by the chairperson of the union parishad and is constituted by various members of society in the union, including physically challenged citizens, ethnic minorities, freedom fighters and adolescents. The union health and family welfare centre provides family planning, reproductive and maternal health services. The facility has two paramedics, two sub-assistant community medical officers and a family welfare visitor, who delivers essential health and family planning services.

The next health-care tier is at *upazila* or sub-district level, which is also considered a PHC tier. At this level, there is an *upazila* health complex, with an inpatient capacity of 30–50 beds. An *upazila* health management committee is formed to support and integrate people's participation. The committee functions mainly as an advisory board and consists of 21 members, with the local Member of Parliament (MP) as chair (Table A1.4).

Table A1.4. Membership of an *upazila* health management committee

Affiliation	Position on Committee
Constituency MP	Chairperson
Chairman (elected), *upazila parishad*	Vice-Chairperson
Upazila nirhabi officer	Member
Mayor, *pourashava* (if available)	Member
One female vice-chairperson, *upazila parishad*	Member
Police officer in charge of station	Member
Upazila social welfare office	Member
Resident medical officer, *upazila* hospital	Member
Medical officer	Member
Upazila family planning officer	Member
Nursing supervisor, *upazila* hospital	Member
Councillor, *pourashava* (if available)	Member
Representative of *upazila muktijodha* command council	Member
Union *parishad* chairperson (female) or nominated by Upazilla Nirbahi Officer (UNO)	Member
NGO representative nominated by UNO	Member
President, press club (if available)	Member
Eminent member from civil society	Member

Affiliation	Position on Committee
Representative of nursing (concerned organization)	Member
Representative of third-class employee (concerned organization)	Member
Representative of fourth-class employee (concerned organization)	Member
Upazila family planning officer	Member secretary

Source: Ministry of Health and Family Welfare, Health Economics Unit (2012)

Secondary care is available at district hospitals, with 250 beds. A committee is similarly formed at this level, which also acts as an advisory board to integrate citizen voices into management of the facilities. This committee does not have a formal structure for participants but is expected to include members of civil society.

Formation of committees at every tier was meant to incite accountability and ownership among the citizens who would benefit directly from the services. The idea was that active participation of committees and local government officials in decisions that affected them would lead to decentralization of power, i.e. the MoHFW would no longer retain central control and the power would be delegated and dispersed, thereby creating participatory governance.

At national level, however, the Government also formed councils to promote wider participation of stakeholders, often chaired by the Prime Minister. These councils include: the Bangladesh National Health Council, with 64 members, the Bangladesh National Nutrition Council and the National Population Council. These councils function sporadically at best, as meetings are held very infrequently. For example, although the National Nutrition Council was formed in 1974, only three or four meetings have been held. Similarly, the National Population Council was formed several decades ago but, according to a member, it has had no activities recently. Parliament, the highest-level legislative body with elected members, is the penultimate platform for increasing voice and participation. Within the parliamentary process, the Government forms Parliamentary standing committees for various ministries, including the MoHFW.

The Ministry of Planning, which develops the 5-year plans, organizes stakeholder consultations with selected groups of professionals, mostly at national level, at the time of developing a new plan. Similarly, the Ministry of Finance hosts stakeholder consultations with selected groups during development of the annual budget.

Civil society is perhaps more active at this level. A few nongovernmental initiatives are considered proxy platforms for voice and participation of broader communities and stakeholders. These platforms organize regular and ad-hoc conferences, meetings, dialogue and television talk shows to elicit public opinion on issues of national interest. Prominent among these platforms are the Centre for Policy Dialogue, Citizens Platform for Implementation of the Sustainable Development Goals, Shushashoner Jonnyo Nagorik (Shujan), BHW, Transparency International Bangladesh, Naripokkho and Bangladesh Health Reporters Forum.

At the start of the pandemic, the Government formed committees for various administrative tiers for COVID-19 management. The COVID-19 Technical Advisory Committee, the most prominent, had 17 members; however, as shown in Table A1.5, the committee was clinical-centric and could have benefited from a broader representation involving related disciplines and backgrounds.

Table A1.5. Membership of the national COVID-19 Technical Advisory Committee

Name	Designation or affiliation	Type of membership
Prof Dr Mohammad Shahidullah	Senior Child Specialist and President of Bangladesh Medical and Dental Council	Chairman
Prof Dr Meerjady Sabrina Flora	Director, Institute of Epidemiology, Disease Control and Research	Member Secretary
Prof Dr Nazrul Islam	Former Vice-Chancellor, Bangabandhu Sheikh Mujib Medical University	Member
Prof Dr AK Azad Khan	President, Bangladesh Diabetic Society	Member
Prof Dr Shahla Khatun	Senior specialist in gynaecology and obstetrics	Member
Prof Dr Mahmud Hasan	Former Vice-Chancellor, Bangabandhu Sheikh Mujib Medical University	Member
Dr Mostofa Jalal Mohiuddin	President, Bangladesh Medical Association	Member
Prof Dr Pran Gopal Dutta	Specialist in ear, nose and throat medicine and former Vice-Chancellor, Bangabandhu Sheikh Mujib Medical University	Member
Prof Dr Iqbal Arsalan	President, *Swadhinota Chikitshak parishad*	Member
Prof Dr Rowshan Ara Begum	Senior specialist in gynaecology and obstetrics	Member
Dr Shams El Arifeen	Senior Director, Maternal and Child Health Research, ICDDR,B	Member
Prof Dr Khalilur Rahman	Senior anaesthesiologist	Member
Prof Dr Tarikul Islam	Senior medicine specialist	Member
Prof Dr Humayun Sattar	Former chairman, Microbiology and Immunology Department, Bangabandhu Sheikh Mujib Medical University	Member
Prof Dr Golam Mostofa	Former head, Pathology Department, National Cancer Research Institute and Hospital	Member
Prof Dr Mahmudur Rahman	Former director, Institute of Epidemiology, Disease Control and Research	
Prof Dr Md Abdul Mohit	Former director, National Mental Health Institute and Hospital	

Source: The Daily Star *(26)*.

A1.5 From the bottom up: health systems and citizen engagement

A3.5.1 Functionality of committees at different tiers

Committees have been formed at various tiers of the health-care system as a State initiative to integrate citizens' voices into decision-making, planning and governance.

CC beneficiaries, the CHCP and the HA in both Sunamganj and Kurigram, expressed disdain for the general situation with respect to infrastructure: "As you can see, we don't even have chairs to

sit patients; I can't even provide clean water to my patients." (CHCP, Kurigram, in-depth interview); "People say there is electricity in every household in the country now, but we don't have access to electricity in our clinic, and this is a health facility." (HA, Kurigram, in-depth interview); "I have seen it myself: many of the clinics here are simply a place to keep cattle. They don't even have doors to keep the cattle out." (Mohila Parishad Representative, key informant interview). There were shortages of amenities, including furniture, a water supply and electricity. There were issues in their upkeep; flood-damaged walls were still unattended many months after flood waters had receded. A case in point was the office of the *upazila* health and family planning officer in Sunamganj, who pointed to his damp walls during the interview and said that it was the case of most clinics: "As you can see the condition of my walls, I have not had the resources to fix it still, and the condition of CCs is much the same or worse". The CHCP and HA at a clinic in Sunamganj said that complaints were lodged but never addressed. In some cases, electricity bills had to be paid from the personal funds of the CHCP: "The electricity bills come from the Trust money, but we have not received anything, so I had to start paying the bills, but I cannot afford so much and so long." (CHCP, Sunamganj, in-depth interview). As a result of inaction, electric lines were disconnected. Among service providers at three clinics in Sunamganj, the most common complaint was about the condition of roads. Rain and floods had damaged the roads, making them unusable by beneficiaries. The HA attested to this, saying, "How will patients visit? These roads are in terrible condition. I have made many pleas; nothing has been done so far." This obviously hampers access by local residents.

CGs and CSGs, formed to encourage a sense of community ownership and to maintain the smooth running of clinics, were not active at either study site. Most people were unaware of them. Operational responsibilities fall to the CHCP, the only health provider in these clinics. She or he receives 3 months of training or, in some cases, a 15-day crash course, before becoming responsible for prescribing medication to villagers, includes for antibiotics.[9] They receive negligible support from the HA and conduct all the work of the clinic. It would be no exaggeration to conclude that the CHCP – overworked, overburdened and demotivated, with little or no opportunity for career growth – feels no sense of ownership or accountability for running and maintaining the facility.

The study sites visited also did not have union health management committees, although they should exist. Local representatives and field support staff were unsure whether such committees had been formed and instead referred to the *upazila* health management committee. This created confusion at Kurigram, where the CG was considered to be the union health management committee. Sunamganj *sadar* had the same problem; however, a union health management standing committee was located. Interviews with members, however, revealed the same issue of unawareness and lack of understanding about their functional roles.

Data collected from the *upazila* health management committee in Kurigram indicated that the committee was not fully aware of its operative duties. It was active only through standalone acts by members, who raised awareness among poor citizens about their health rights or personally escorted them to the *upazila* health complex for treatment. Thus, micro-concerns have no way of reaching a solution. A public policy analyst and key informant noted that political leaders should be incentivized for public service. It is understandable that a Member of Parliament may not have the time to chair meetings. There were reports of poor functionality and accountability in many of these committees, and the potential and need for parliamentary institutions to step up efforts. If local authorities are not politically mobilized to ratify local decisions, citizens will falter and fail, which has been the cause thus far.

9 In a speech delivered at a conference on UHC on 10 May 2023, the Prime Minister declared that use of antibiotics at CC level would be discontinued.

Meetings of district health management committees are also held rarely, even though members are aware of the deficiencies of and the necessities for the health system. The situation was similar in Kurigram and Sunamganj, with either no or inefficient meetings. A representative of the sadar hospital in Kurigram said during a focus group discussion that he had been a member of a committee for 4 years and had attended four meetings! Another member of the committee commented that, when meetings were held, they were perfunctory at best: "You go in, sign a piece of paper, maybe have tea and biscuits, and leave". This was substantiated by journalists and other committee members at both sites

A1.5.2 Care and referral systems: persistent issues

The CC is the basic unit for PHC delivery. CHCPs, the sole health-care providers in these clinics, are aged 18–30 years at the time of appointment and are obliged to have higher secondary education and adequate knowledge of computers (MSWord and Internet) (see, e.g. https://www.bdresultjob.com/2018/02/CHCP.html). The clinics provide medication for chronic and common illnesses and also diabetes, blood pressure and weight checks, the nutrition level of young children and counselling on nutrition and maternal health. Training of CCs was an attempt by the Government to create a strong referral system, so that patients who have a health concern that the CC service cannot address are referred to the *upazila* health complex and, if necessary, to the district hospital.

The other duties of the CHCP take more time than actual medical services, as they have to observe Government-mandated days, attend to visitors, manage cleanliness and crowd control and other duties. Although the aim is for CCs to be strong referral points, the referral system is weak. CHCPs who refer patients to an *upazila* health and family welfare centre are not always respected and may be met with hostility, further challenging effective community engagement in health. According to the CHCP and other committee members, patients go to a hospital with a reference slip, but no one takes them seriously until a broker or syndicate finds them, which costs them a lot of money. This undermines their trust in the health system. One CHCP reported that a patient said, "*Bouma* (daughter-in-law), I went there following your advice, and now they gave me a test that costs 1400 *taka*".

The *upazila* health complex is a 50-bed health facility, which struggles to provide for the number of patients that arrive. The referral system functions poorly. Patients are referred by CCs and are promised free treatment, but, upon arrival at the health complex they learn that further payment is required to access the promised services. A relative of a CHCP in Sunamganj came back disheartened from an *upazila* health complex, claiming, "You told me that the treatment will be free but I went there and they kept asking me for money. I didn't have that money and so, I didn't receive any treatment."

This is the common practice of *a third party or middleman* who offers brokering services unlawfully. To access the services to which they are entitled, people must make cash payments to the third party, who will then fast-track a visit to a doctor and the testing process. A journalist in Kurigram said:

> There are about 20–25 *dalals (unlicensed brokers)* active in front of each hospital at any given point of time. If you come with me now, I will show you. If doctors prescribe you diagnostic tests, they will snatch your prescription from your hand and take you to run the tests. They act as though they are doing you a favour but they do it because they receive a percentage of fees generated from

the diagnostic clinics. If a *dalal* can take 3 patients to the clinic, they receive a commission of 500 to 700 *taka*.

Health facilities are widely considered to provide slow services or, in some cases, deny services altogether. Citizens who are unaware of their rights or of the services that health-care centres provide find themselves in a state of frenzy and confusion. This has been a driving factor in the rapid increase in the number of such *brokers (27)*.

Slow or lack of services is due to a shortage of relevant skilled human resources. Most participants referred to a shortage of workers. In Mohila *parishad*, one informant stated that the district hospital at Kurigram had access to advanced medical equipment but no technicians to operate it. The Civil Surgeon of Kurigram, the highest ranked MoHFW bureaucrat in the district, agreed, saying, "One of the biggest problems we are facing now is the shortage of health human resources because in the past 10 years, no recruitment has been made at the 3rd and 4th class levels in the health-care sector". Half of the posts at the district hospital were empty. It is not feasible to provide health care in hard-to-reach areas when there is a nationwide dearth of health workers.

Health professionals and other public sector workers are hesitant to work in rural areas. Medical officers posted to Kurigram and Sunamganj immediately try to be posted to other cities, seek leave for training or use other means to be relieved of their duties in these areas. Adjustment to a remote, rural environment is difficult, especially for people who grew up in cities and well-to-do households. In the words of the Civil Surgeon of Kurigram, there is "class disgust", a tendency to look down on these populations. He noted, "Doctors need to have *heart* for those they treat, someone coming in from outside will not have the same sentiments for the condition of the people living here".

A journalist in Kurigram stated that, when people do not receive the services the State promises them, they are disheartened, lose faith in the institutions and ultimately turn to private facilities for care: "Perhaps, it will cost more, but at least they know they will get the right treatment".

Perception among several sections of the population is that Government health facilities provide poor-quality treatment; for most: public health care is bad, private is good, and for whoever can afford it, it would be a wiser option to seek services abroad. The Civil Surgeon of Kurigram said, "Rich people in Bangladesh think that if they do not die at Mount Elizabeth Hospital [in Singapore], then it wouldn't be a proper death".

Suboptimal procurement practices lead to gaps in access to State-sanctioned essential medication and nutritious meals. The quality and quantity of food for in-patients have often been reported to be subpar. Other data show that only 16 types of medication are received by certain CCs instead of the 33 they are entitled to. In cases when all 33 types of medication are received, the quantities disbursed are smaller.

According to the Budget allocation rules, local governments are supposed to spend 15% of their financing on health. Many upazila health complexes and district hospitals ensure resources from local governments through effective engagement with them. This community financing may fill the gaps to a certain extent. Due to the scope of this study, community financing issues are not captured.

A1.5.3 Community engagement and coordination during the COVID-19 pandemic

The situation was different during the COVID-19 pandemic. In some areas, people participated in awareness campaigns and adhered to imposed regulations and mass vaccination. WHO targeted

vaccination to 70% of the population, corresponding to 119 221 953 people in Bangladesh. Of these, 131 182 263 people registered via the *Surokkha* App. COVID-19 vaccination coverage in the Rangpur division was 84.2% with the first dose and 79% with the second, and Sylhet divisional coverage was 85.4% with the first and 79.3% with the second dose (Health Emergency Control Centre, DHIS2, *Surokkha* App, 2023; http://103.247.238.92/webportal/pages/dghs_controlroom_menu.php**).**

The Government was primarily responsible for ensuring mass vaccination. They involved local people and their representatives to create campaigns, hoist banners and spread audio announcements to raise awareness and caution about COVID-19. Beneficiaries at the study sites were well informed about the regulations to be maintained and praised the advocacy of local organizations. The Civil Surgeons of both areas attested to local involvement and were convinced that disaster management on such a scale would not have been possible if the community had not been included in decisions from the beginning of vaccination.

At the beginning of the crisis, a COVID-19 Coordination Committee was (said to have been) formed in each district, with members including people from other committees at different tiers to oversee policy and impact and formulate new mechanisms to address issues. For better coordination, two sub-committees were subsequently formed: the COVID-19 Prevention Committee and the COVID-19 Vaccination Committee. These committees were not, however, located in Kurigram. An official of the Sunamganj COVID-19 Coordination Committee said during a focus group discussion:

> Even with a manpower deficit, we reached close to a 100% success in the vaccination programme. The community helped a lot in both vaccination and prevention. We are calling it an interdepartmental coordination. All sectors, especially the community effectively indulged in decision and implementation. We vaccinated 11 lakhs and sixty-seven thousand people in one day!

Box A1.1. Community engagement enhances COVID-19 vaccination for marginalized people

One of the few ways that people can survive the global COVID-19 pandemic is vaccination. A mass vaccination programme was initiated by the Government, after a long delay to overcome numerous obstacles. Despite Government efforts to resolve the supply crisis, vaccinating people in underprivileged communities remained a challenge. Poor people, women, people living in remote areas and people in other marginalized communities were at risk of not being vaccinated due to lack of adequate information and technological facilities. In these circumstances, the BHW, a civil society initiative, embarked on helping in vaccination registration and promotion through its regional chapters. In Kurigram, BHW worked with its local partner, the NGO Solidarity, which was entrusted with managing campaign activities on the ground. A BHW-sponsored "district health rights forum" and a "health rights youth forum" disseminated vaccination information to people in disadvantaged communities, especially in the remote villages of Hatia Union of Ulipur *upazil*a in Kurigram District, and to women and socially disadvantaged communities. A 2-day campaign was conducted, with microphones, streamers and banners, across the union. Fifteen volunteers in five teams (with at least one woman in each) registered people who wished to be vaccinated in eight centres, free of charge. Local government representatives and influential people were also involved. The campaign was a success, with 1000 people vaccinated in Hatia Union alone, three times more than in neighbouring unions. The BHW campaign with Solidarity and the free registration initiative attracted more people to be vaccinated.

Community engagement during the COVID-19 was initiated in both Kurigram and Sunamganj districts. Although community participation is necessary to ensure UHC, it is not common in Bangladesh. Nevertheless, COVID-19 somehow encouraged it, even in rural areas. This indicates that, if community participation could be ensured in every aspect of the health sector, UHC could be fast-forwarded. Research shows that it is no longer sufficient to rely only on medical professionals and health-care workers to combat the COVID-19 pandemic and reduce its impact on society *(28,29)*. For instance, a study in China, where the virus was first discovered, showed that relying solely on experts in disease control and bureaucracy to address the pandemic is doomed to failure. Citizens, non-State organizations and even government agencies should be included in formulation and implementation of central Government policies at every level *(30)*. An important lesson from this study in Bangladesh is the positive role that NGOs played in enhancing community engagement. NGOs such as BRAC, the Sajida Foundation and the Hunger Project participated in State efforts to combat the crisis. A case study of how a local NGO, Solidarity, in Kurigram contributed to enhancing COVID-19 vaccination of a group of neglected communities is shown in Box A1.1.

A1.6 Macro-level initiatives to integrate citizens' voices

A1.6.1 Engaging civil society

In a democratic approach to health, the Government of Bangladesh sanctioned committees at various tiers to strengthen community involvement in the public health system. The initiative began with the 5-year plan for the health and population sectors (1998–2003), which states the importance of stakeholder consultation. The MoHFW subsequently established local stakeholder committees to monitor service delivery *(31)*. In accordance with the public–private partnership model, the Ministry worked with four NGOs: Nijera Kori,[10] BRAC, the Voluntary Health Service Society and Mohila *parishad*, in a pilot project to form local committees with community representatives in nine districts.

The general guidelines for selecting participants were simple: they should include various social and professional groups. Nijera Kori requested that 50% of the members be women and specified the inclusion of "two members from landless groups, two professionals, one teacher and one service-delivery person, a union *parishad* member, and two representatives from the union stakeholder committees". At the request of the community, doctors and other medical staff were excluded from membership because of an increased risk of conflict of interest.

Reports show transparency in participant recruitment and success in establishing dialogue, even for committees that lacked political authority to ratify local decisions or provide feedback on systems and management *(31)*. The situation has not, unfortunately, evolved. Committees now also include minority groups, freedom fighters, physically challenged people, adolescents and senior citizens, with up to 51 members per committee at the CC level. This has resulted in "too much involvement" for effective action. As mentioned by a senior national health expert, "too many cooks spoil the broth".

The reason for the non-functionality of committees appears to be the similarity of themes. Conversations with key informants suggested that committees were created simply as tool for representation but added little functional value. In theory and by design, they should add to effectiveness by creating a participatory system of governance. Much of the problem, however, lies

10 A reputed NGO that works for the rights of the woman and advocates for female representation on various national committees and entities

in lack of technical guideline on the assigned roles of each committee. Committee members at both study sites were unaware of their assigned responsibilities, mainly because there were none. This conclusion was substantiated by national health veterans, who confirmed the dearth of information and awareness among CGs. It is therefore essential to provide them with a sort of blueprint of their role. This might not result in better functioning committees, because, in some cases, such as the union health management committees in both Kurigram and Sunamganj *sadar*, it is not certain whether they exist. If they do, their members are unaware that they are, in fact, members. Some research indicates that members who are selected only according to criteria are often inefficient; the selection criteria should include a requirement for citizens who are politically mobilized before recruitment. Other functional deficiencies include poor meeting structure and leadership. Negligible attempts have been made to activate, revive or revitalize these committees for better community engagement.

A1.6.2 Increased stakes for civil society

While civil society plays an integral part in development, especially to ensure civic trust and engagement, an overly active civil society may indicate weaknesses of state and governance *(32)*. In Bangladesh, NGOs emerged in the absence of a functional state, to reconstruct and mobilize the then newly sovereign state after the war in 1971, which was followed by a famine in 1974. Although the nation has come a long way since, civil society engagement has been retained only by NGO involvement. A study in 2006 *(31)* reported a total of 22 000 active NGOs in the country, about 1250 of which received international donor funds. The study also showed that about 78% of villages benefitted directly from at least one of those organizations, and 35% of the population received direct services for health, micro-credit, education, sanitization and other needs.

Donor organizations tend to prefer civil society organizations because of their affiliation with communities, which provide access for direct service delivery. One member of the district health management committee in Kurigram said that it was easier to establish open dialogue with such groups on issues in the health-care system, simply because they allowed that scope.[11] There is no acknowledged way to initiate dialogue with the Government. Other than State-sanctioned committees, the State does little to integrate citizens' voices, and the inefficacy of committees precludes raising an issue to a position from which a solution can be found.

Committees at various tiers are more functional with external support. For example, the *Upazila* Health Management Committee in Kurigram may have deficiencies similar to those of all the other committees investigated but remains active at individual level[12] due to the persistence of a local NGO, Solidarity. This NGO works with populations affected by natural and social disasters and areas prone to *monga*[13] in Kurigram district. It has made various attempts to revitalize committees at *upazila* level through close monitoring, which inevitably raised the bar for accountability. Solidarity has also been directly involved with health: a project funded by Manusher Jonno Foundation to eliminate child labour required that a doctor with Bachelor of Medicine and Bachelor of Science degrees conducted

11 Civil society organizations have platforms or forums that allow citizens to participate in open dialogue, resulting in more effective engagement. The forums and platforms include: Bangladesh Health Reporters Forum, Bangladesh Non-Communicable Diseases Forum, Bangladesh Health Watch, Centre for Policy Dialogue, Citizens Platform for the Implementation of the Sustainable Development Goals, Transparency International, Naripokkho and the Hunger Project.

12 The Committee is active because members that belong to civil society organizations use their membership to raise awareness among poor citizens about their health rights or take them personally to the *upazila* health complex for treatment, thus boosting their social credibility.

13 *Monga*: Bengali term referring to the annual cyclical phenomenon of famine in some areas of the country.

health checks of child workers in hard-to-reach areas. A similar initiative by Mohila Parishad with equally accredited doctors set up health camps in villages to monitor and analyse the quality of health, facilities and services. Expenses for the operation were provided by Mohila Parishad. A key informant from the NGO noted the absence of any such initiative by the Government, commenting that, even if permanent positions for doctors cannot be created in remote places, they could be sent regularly as a part of their service duties, as:

> That is what the people want. A doctor. It isn't that difficult to post a doctor, at least one that will visit once a week. [...] If the Government wanted, why can't it be made mandatory for doctors, as part of their duties, to make field visits in remote places? Okay, you can't make permanent positions, but this is doable, no? You have to have the right intentions.

Health management committees at all tiers have not been self-sustaining. As the national director of an international NGO pointed out, civil surgeons are active in public health only when mobilized by an NGO.

To ensure a sustainable participatory system of governance, BRAC initiated a CC revitalization project and now works to make 8500 CCs functional by mobilizing CGs and CSGs. This started with a training programme to ensure that members were aware of their responsibilities; then, community mobilizers ensured that regular meetings were held and that the reports were sent periodically to the *upazila*. Although the model was successful, the Director of the BRAC Health Nutrition and Population Programme noted that it was now up to the Government to decide whether they would scale-up the model or implement it at all. It should be noted, however, that these are all circumstantial, technical, top–down interventions, which is not the ideal process for community engagement.

Why is it that, as a nation, Bangladesh has been unable to achieve a sustainable participatory system of governance? In many discussions, it was found that school management committees were more effective than health management committees, as they determine the overall quality and governance of a school and act as a bridge between schools and communities (parents). Our research shows that health management committees at all levels, although prey to politicization, do not require external interventions to make them functional. The reasons include general neglect and lack of incentive to improve health, whereas, in education, there is a more personal motive, as the results, students' performance at school, are more direct and tangible. Education is also often given greater significance, because the quality of schools has a direct impact on their own children. There is little or no personal motivation or sense of ownership to support Government health facilities because there is no guarantee that the services being offered will be of use, and people prefer private clinics. Discussions with key informants led to the conclusion that external intervention is necessary to duplicate the school management committee model in health. The established system has faltered and failed, and there is little scope for internal rejuvenation. Furthermore, the State has no political urge to improve the situation because, at present, it cannot undertake revitalization without support, which may not suffice in any case.

For example, the public–private partnership model that the Government used for establishing CCs across the country was designed to instigate a sense of ownership among local residents; however, there appears to have been an ulterior motive in donating land for a CC. It is somewhat of an open secret that donations were made to secure jobs in the clinic for family members. Health veterans pointed out that the land donors were not usually people of means; therefore, the donation

was unlikely to be for income generation, which was possible for CHCPs. Members of CG and CSG work on a voluntary basis.

Whatever the case, the pattern thus far is that the State creates a mechanism to integrate citizens' voices, but effective implementation is achieved by civil society and NGOs. It is not that the people have greater trust in nongovernmental entities, but, often, an external force is required to run a Government initiative *(32)*. Key informants in Kurigram and Sunamganj *sadar* commented that this type of involvement was rarely long term, as funds dry up, projects end, and, in time, the situation reverts to its initial state.

A1.6.3 Persistent issues in decision and policy

Current policy mandates that at the upazila and lower levels, 75% of the medicines are to procured from the government-owned Essential Drug Company Limited (EDCL) and 25% from other sources. However, without any electronic drug management information system, this procuring method results in either medicinal shortages or surplus. The plan that one CC be established for every 6000 people may also have to be revised, as it results in some areas being deprived of any form of PHC. For example, in Sunamganj, overlapping of three unions in close proximity results in excess medicine, while in Kurigram, people often hold small-scale demonstrations in front of CCs seeking essential medicines because of shortages. Our study found no evidence of attempts made to rectify the situation, which is due to poor planning and exclusion of particular groups. Women, for example, are excluded entirely, while their inputs are essential. A *mohila parishad* chairperson noted:

> In regards to women here... we'll sometimes go to talk to them. Their thoughts are more or less the same: "whatever my husband says" or "whatever my father/ mother-in-law says" is the custom. They don't step beyond what's chosen for them by either their husbands or their in-laws or the society at large. That is an important reason why they don't get the right treatment the right way. And the pain that pregnant women face.... I don't know what to say about that. We witness it ourselves, it pains us to see the pain they endure. But we cannot find a solution for it, we don't have that capacity. It's a big reason that women have a very high mortality rate here, in these areas.

Thus, women in rural areas are dependent on the patriarch of the family, including having to ask permission to see a doctor – with further complications when the doctor is male, as these regions tend to be religiously conservative, and women are generally uncomfortable in the presence of unrelated men. Furthermore, medical assistance depends on where a medical facility is located. Naripokkho, a women's activist organization, reported that women will not and cannot go to a hospital or clinic if it is near a public space, such as a bazaar, especially if the entrance is in the bazaar. The State must take this into account. Current arrangements do not account for the situation of women when planning the location of a medical centre. The *upazila* health and family planning officer in Kurigram also expressed his concern. He said that, because of State allowances,[14] men do not require allowances for health care, while immediate attention should be paid to the dire state of health care for women.

14 The Cabinet has issued a directive to the Ministry of Public Administration and the Finance Division to introduce allowances for people working in remote *upazilas*. Other allowances include those for unemployment (up to 1000 BDT per head) and disability.

A professor and gender specialist at Dhaka University noted that, in a neoliberal economy, 72% of smartphones in rural and urban slums are used by men. Thus, although there are about 20 health-related apps, only about 28% of women in these areas can potentially benefit from them. Although they are the primary beneficiaries, women's voices are grossly neglected in health care. Female union *parishad* members are not vocal and are therefore not instrumental in advocating for their health rights. Attempts should be made to mobilize women politically, to hear their voices and their agency to speak and, ultimately, integrate them into the local power structure.

This gendered perspective of health emerges primarily from the grassroots. National issues were also raised in discussions with key informants, including medical documentation. Health veterans deplored the nationwide dearth of documentation, saying that, without it, "achieving UHC is simply not possible". A cross-sectional study in Chittagong Medical College on record-keeping showed "important defects", lack of training of record-keeping personnel and consensus that a computerized system was necessary *(33)*. In an opinion piece in *The Business Standard* – a local daily newspaper – Dr Md Faisal Kabir Rozars related his first-hand experience of the adverse effects of inadequate documentation, stating that "it's a burden for patients" and can cause "untimely, avoidable deaths" *(34)*. The District Health Information Software 2 (DHIS2) can recover data from previously fragmented repositories and integrate it into a unified system for ready access among health-care facilities *(35)*, although it is too early to determine whether it could adequately serve as a public health data storehouse.

A1.7 Challenges and opportunities at the national level

The importance of community engagement in health is well known. It is a crucial for promoting health and well-being, as it enables changes in behaviour, environments, programmes and policies for positive health outcomes. Although the tangible benefits of engaging communities are well known, many facets have not been achieved due to challenges.

First, it is crucial to understand the process of policy-making. Policies are an essential aspect of a community's health system, as they guide the allocation of resources, delivery of services and, ultimately, the health outcomes of individuals and populations. Understanding how policies are made, implemented and evaluated helps to identify the stakeholders, power dynamics and interests involved and how they influence decisions. It can also assist in identifying potential barriers and opportunities for community engagement in health, the right time to engage with policy-makers, such as during policy formulation or implementation, and the most effective strategies for engagement, such as advocacy and coalition-building. It can also help in determining the appropriate level of engagement – local, regional or national. Formulation of the 5-year plans is described below as an example of how national policies are made and the stakeholders involved.

In Bangladesh, formulation of a 5-year plan involves various stakeholders and decision-makers. First, a policy is drafted by each ministry. The policies are then compiled into a single document and shared with other ministries and Government departments and is posted on the Planning Commission website for virtual feedback from citizens. Divisional consultations and inter-ministerial feedback are solicited to ensure that the policy is aligned with the Government's broader development agenda. Stakeholders in the private sector and independent researchers are consulted in meetings and workshops arranged by the Ministry of Planning to ensure that the policy is inclusive and comprehensive. The policy is then presented to the Parliamentary standing committee for scrutiny and feedback. The Head of Government also provides feedback. The policy is then presented to the

Executive Committee of the National Economic Council for final review, before it is placed before Parliament for notification in the official gazette.

This process ensures that 5-year plans in Bangladesh are formulated in a consultative, inclusive approach that involves many stakeholders and decision-makers. It also ensures that policies are aligned with the Government's development agenda and goals and respond to citizens' needs and aspirations.

Role of stakeholder engagement in making a sector plan

Bangladesh is now formulating its fifth sector plan for the Ministry of Health and Family Welfare. First, an 11-member committee was established to develop a strategic investment plan. Each committee member was assigned an area for further development (Table A1.6).

Table A1.6. Thematic areas for development of a strategic investment plan for the Fifth Health, Nutrition and Population Sector Programme

Mr Md Humayun Kabir	Chair
Dr Md Waheed Khan	Vice-Chair
Thematic area	Consultant
Health Financing and UHC	Professor Rumana Huque
Sector Management and Governance	Dr Md Khairul Hasan
Quality and Affordable Drugs	Professor Sayedur Rahman
Medical Education and Development	Professor Enayet Hussain
Human Resource Planning and Management	Dr Abdus Sabur
Health Care Provision	Dr Zakir Hussain (Urban and Rural PHC) Dr Asib Nasim (Secondary, Tertiary and Specialized care) Dr Khaleda Islam (NCDs and Mental Health)
Financial	Mr Md Faruque Hossain (Procurement and Supply Chain) Mr Ranjit Chakroborty (Management and Financial Management and Audit)
Health Information Management and Digitalization	Mr SM Ashraful Islam
Sexual, Reproductive, Maternal, Neonatal, Child and Adolescent Health and Family Planning	Dr Shehlina Ahmed Dr Abu Jamil Faisel (Family planning)
Communicable and Emerging Diseases	Dr Mohammad Mushtuq Husain
Pandemic/Epidemic/Outbreak Preparedness and Response	Dr ASM Alamgir Hossain
Nutrition	Dr AFM Iqbal Kabir
Climate Change, Environmental Health including Medical Waste Management	Dr Md Badiuzzaman

Table A1.6 illustrates the broad thematic interests of the Government. Although community engagement and participation are not included, they are expected to be cross-cutting in each of the 11 themes. As there is no section for community engagement in any thematic area, it is suggested that it be included in each. At the time of writing, the plan is being further developed. The Committee has met several stakeholders from relevant departments of the MoHFW, development partners, professional associations and the pharmaceutical industry. Engagement was extended during a consultation in Khulna, with 200 participants. This high-profile meeting, attended by the Secretary of the MoHFW and other senior bureaucrats, also included representatives of the Khulna City Corporation and local MoHFW staff, including several laboratory technicians, midwives, sub-assistant community medical officers and the Rotary Club. The discussion was limited due to the number of participants, the absence of broader civil society and the time available (only a few hours). Broader civil society is yet to be consulted.

Nevertheless, civil society think tanks play a significant role at national level in formulation of the budget and of plans. The think tanks that are active in this regard include the Centre for Policy Dialogue, Transparency International Bangladesh, Sustainable Development Goals Core Group, Bangladesh Health Watch and Shujon.

A1.8 Discussions and conclusions

Community engagement in health in Bangladesh is challenging because of an overpopulated committee system, lack of monitoring indicators, inadequate training, weak support and referral systems and malfunctioning health-related committees. The lack of monitoring indicators in the policy of CCs results in poor coordination, confusion and anomalies in clinical oversight. The Government considers it necessary to monitor communities, as public–private partnership models fund the clinics, and community members are unaware that they also should be involved. Inadequate training of staff and shortages of medicine for CCs further impede effective community engagement in health.

A1.8.1 Challenges

Overpopulated local committees: Local committees in Bangladesh have too many members, which makes it difficult to organize meetings. For instance, CCs at the lowest health system tier have 68 members, and the CG, which has 17 members, is supported by a CSG, with another 51 members.

No monitoring indicators: The lack of monitoring indicators in CC policy has resulted in anomalies, lack of coordination and confusion in clinic oversight. Community members are convinced that the Government conducts monitoring, while the Government considers that community monitoring is essential to ensure community participation and engagement.

Roles and responsibilities of CGS

First of all, most CGSs are not aware of their roles and responsitbilities. Mostly their decisions and recommendations for the CCs remain unheard or unaddressed. This inaction from the authorities discourages them to have regular meeting and make further decisions.

Training

> To make the CCs more active, they should arrange some training for one or two months with an honorarium. If an honorarium cannot be arranged, they can be offered a gift or a prize. This will motivate group members. – Member of a CG

CHCPs receive 3 months of training (in some cases, 2 weeks of refresher training) and are then authorized to prescribe 33 types of medicine. According to key informants, the training is inadequate for such an important responsibility. More training should be provided for effective community engagement in health. Although refresher training is also essential, there is currently no allocated budget for training in CCs.

Oversight groups for citizen engagement

The Government should develop new assessment and outcome-based modules in which NGOs, civil society and citizens groups are given oversight of health care in Bangladesh. Bangladesh Health Watch, Bangladesh Education Watch, Socheton Nagarik Shomaj, Youth Engagement and Support, Shushashoner Jonno Nagorik and others are citizens' watch groups that monitor Government services and facilities. Patronage and strengthening of these groups would enhance community participation at various levels in policy and practice. Community clinics should have a local citizen oversight group to maintain accountability and transparency. Currently, there is no effective system for citizen engagement, and the CG does not provide opportunities for gender-balanced representation.

Dysfunctional health committees

Health-related committees in Bangladesh are dysfunctional, as significant gaps in governance complicate effective community engagement in health. There is little coordination or communication between health and other committees, resulting in poor governance and inefficient community health programmes. Committees concerned with health and related issues at various levels include: committees at village, union, *upazila* and district levels, the National Nutrition Council, the Health Council, the Population Council and the Parliamentary standing committees. Most these committees are not very active. For example, the Nutrition Council has held two meetings since its inception in 1975, and the Health Council has not yet met. The Parliamentary standing committee and district and *upazila* committees meet very occasionally. Lack of budget and motivation and the low priority of the heads of the committees are some of the reasons for their dysfunctioning. The *upazila* committee, for example, is headed by the local MP. In Bangladesh, most MPs live in the capital city and visit their constituencies infrequently. Some of the interviewees reported that, when an MP visited an *upazila*, health was a low priority, and the health committee rarely met. When they did, the MPs spent most of their time scolding doctors and using them as scapegoats. The doctors were discouraged, and the meetings became the real victims.

It should be noted that Government policies stipulate local engagement through creation of committees; however, there is no agreed design for engagement of the broader community at national level. Anything achieved in the public sector is ad hoc, such as formulation of plans and national budget proposals. The gap is minimized, fortunately, by the pro-active role of some think tanks maintained by non-State sectors, such as the Centre for Policy Dialogue, BHW and Shujon.

Role of NGOs at the local level

NGOs have been active in implementing various public sector programmes, including oral rehydration therapy, vaccination and directly observed therapy for tuberculosis. They have also connected public sector programmes with communities. NGOs helped to cover a significant number of neglected community members in the COVID-19 vaccination programme. In our meetings with some rights-based NGOs, we were told how their involvement helped to activate some of the CC and *upazila* committees. As most NGO initiatives are time-bound and donor-supported, they are discontinued at the end of the project. It is important that the Government support (financial and other) such work for the greater benefit and sustainability of Government health programmes.

Kinship

The role of kinship in community health engagement is significant in Bangladesh. The country is a kin-based society, and most people, particularly in rural areas, are connected. This can, however, result in nepotism and favouritism, further impeding effective community health engagement, as qualified individuals may be excluded from leadership positions.

Frailty and fracture

> There was an old man who needed water here, but we couldn't provide water. There is no electricity, if electricity can be managed, we could influence the community to provide fans and light. – CHCP, Kurigram.

Many health facilities in Bangladesh lack basic infrastructure and physical facilities, such as furniture, electricity and a water supply. Structural inequality in the health sector is not reflected in the policy, and CGs are often concerned only about the shortage of medicines. As reported in Kurigram, the supply of medicines arrives every 3 months, and 70% is used within 3 days. The CCs and *upazila* hospitals have had the same problem for years, with no solution.

Insufficient human resources

> A medical doctor or a nurse is much needed because it is not possible for one person to do all the things single-handedly. For example: if a female patient and 5 other male patients come at the same time, I cannot attend to them all at once. If more support persons (CHCP or nurse) could be here, then it would have helped me a lot. These matters are to be solved. If there is trouble, in any corner of the place, only I have to come and sort this. – CHCP, Sunamganj.

Human resources remain a significant challenge in the health sector of Bangladesh. This was highlighted by *upazila* health and family welfare officers, civil surgeons and the supervisors of district hospitals as the primary obstacle to efficient functioning of the health-care system. They have been using "quick fixes", but at least double the number of human resources currently available are required. "Children play around, goats are roaming here, which make the facility and surrounding place dirty. There is none except me who is going to clean this place."– CHCP, Sunamganj.

CHCPs and beneficiaries have both reported that lack of human resources affects the cleanliness and hygiene of health facilities. They have suggested that a permanent sweeper be appointed for each clinic.

> We have to go to Ulipur for paracetamol, we have to go to Kurigram district town to see a good doctor. We are benefitted by the medicines that we get from CC. But other than that, I personally think that if a nurse or paramedic could be available there in the clinic, it would have been more beneficial. Also, a permanent sweeper needs to be appointed here. – Beneficiary, Kurigram.

Shortage of human resources is a longstanding issue in the health sector in Bangladesh. According to a report by WHO *(36)*, Bangladesh's health workforce density is much lower than the recommended threshold of 2.3 health workers per 1000 population. The report suggests that Bangladesh should increase the number of health workers and improve their distribution to provide adequate, high-quality health-care services to its population.

A1.8.2 Opportunities

Bangladesh has made significant progress in improving its health infrastructure, and a range of health facilities are available, from tertiary care hospitals to CCs. The facilities are, however, understaffed and lack monitoring and good governance. Community engagement in policy formulation and implementation and monitoring of health-care services is minimal. Citizens must make the health system more proactive and people-friendly.

The health infrastructure in Bangladesh covers national tertiary to village grassroots levels. In addition to four medical universities, 25 teaching and tertiary care hospitals, there are about 500 *upazilla* health complexes, 5000 union subcentres and nearly 14 000 CCs. They could be made more accessible and people-friendly by enabling citizens to contribute to their governance and functioning.

The demand for health care in Bangladesh is weak, as people are unaware of their needs and rights and also of the various facilities available and how to access them. This is particularly true of people with a low income and marginalized groups, who are often excluded from the benefits offered by the State.

Currently, the Government and NGOs focus on policy interventions, from which people demand immediate benefits. The demand side of the health care system should also be improved, by ensuring that citizens are aware of their rights and can demand better services. This will require a public policy intervention to address lack of awareness. In the context of wide income asymmetry, the upper–middle and upper income groups reap most of the benefits. The health-care system must be accountable and responsive to the needs of people at all socio-economic levels. Thus, health-care policy should shift from a supply-side to a demand-side approach, by strengthening citizens' participation and engagement.

Development of health policies is often viewed as routine and donor-driven. Consultations with stakeholders are not always sincere and do not always accurately reflect the perspectives of the wider community. For example, a consultation on a sectoral plan in Khulna district appeared to involve citizens' participation but was in fact structured and proforma.

People in different tiers tend to interpret "support" in economic terms only. Many community members consider that that they cannot support initiatives financially although they could contribute in other ways. A community leader in Sunamganj district said: "We have minds, but we don't have the ability, which is why we cannot support financially". People could be educated and sensitized to the fact that support can take different forms, including active participation and engagement with health facilities and functionaries. Creation of incentives, such as identity cards for committee

members, could increase community engagement. Community members sincerely wish to participate when called upon, saying that "If good people call for a good cause we respond immediately".

COVID-19 showed the opportunities that can also be taken during "peace time". With the support of local NGOs, local communities and their organizations played a catalytic role in addressing the challenges posed, including vaccination. Bangladesh has ample examples of successful Government–NGO collaborations, which are considered an important reason for Bangladesh's success in reducing mortality and morbidity and improving population well-being. Unfortunately, such collaboration has taken a back seat in the recent past. With less international donor funding, there is noticeably less space for NGOs to function effectively. The Government must consider this situation and make deliberate efforts to engage NGOs in policy-making and implementation of health programmes. As international donor funds shrink, the Government should come forward to provide financial support for the engagement of NGOs.

A1.8.3 Concluding remarks

Participation could be enhanced within the existing institutional space, and committees should be proactive both internally and externally. The Government and NGOs should extend their roles to active engagement in both policy and advocacy, in addition to active implementation and service delivery. The community could be engaged through the Government and civil society by changing their activity from a proforma exercise to active citizen engagement. The Government should welcome consultation with professional and rights-based groups.

Central and regional institutions (legislative, judiciary and administration) should be made functional. Micro-interventions at local and community levels should be supported by macro interventions at central level. Power should be decentralized to the various administrative levels, and executive decisions by ministries and the central administration should be minimized.

Political leaders must be incentivized through active engagement of the Parliamentary processes and standing committees. Citizen engagement should be encouraged in awareness-building programmes in the mass media. Community engagement must be integrated as a systemic approach.

Community engagement is made possible by: (i) providing information to individuals and communities about their health rights, facilities and services, such as in public service announcements, fact sheets, information kits and websites; (ii) asking individuals and communities for feedback on existing health services; (iii) involving communities; and (iv) ensuring partnerships between elected officials and the community. With this level of engagement, communities could define their own goals and contribute to decisions on collective health issues, brokered by organized civil society groups, including NGOs.

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Appendix A1.1. Number of interviews conducted at the two study sites

Key informants

Name	Affiliation	Organization
Professor Dr Liaquat Ali	Former Vice Chancellor, Bangladesh University of Health Sciences	Prothikrit Foundation
Ms Asfia Azim	Nutrition Specialist	Nutrition International and UNICEF
Dr Morseda Chowdhury	Director	Health, Nutrition & Population Programme, BRAC
Professor Dr Sadeka Halim	Professor and Chairperson	Department of Sociology, University of Dhaka
Professor Dr Maruful Islam	Professor	Department of Development Studies, University of Dhaka
Dr Debapriyo Bhattachariya	Distinguished Fellow and former Executive Director	Centre for Policy Dialogue
Professor Dr Iqbal Arslan	Former President and former Pro-Vice-Chancellor, Bangabandhu Sheikh Mujib Medical University	Bangladesh Shadhinota Chikitshok Parishad
Ms Samia Afrin	Member and Project Director	Naripokkho
Dr Iftekharuzzaman	Executive Director	Transparency International Bangladesh
Professor Dr Rumana Hoque	Professor Vice-Chairman	University of Dhaka 5th Health Sector Planning, MoHFW
Dr Ubaidur Rob	Country Director	Population Council
Dr Shamsul Alam	Minister	Ministry of Planning

Numbers of interviews conducted at the two study sites

In-depth interviews

Kurigram (Ulipur)	No. of Interviews	Sunamganj (Sunamganj *sadar*)	No. of Interviews	Total
CC exit interview with a beneficiary	2	CC exit interview with a beneficiary	2	4
Union UHC and Health Management Committee	2	Union UHC and Health Management Committee	2	4
Upazila Health Management Committee member and NGO representative	2	*Upazila* Health Management Committee member and NGO representative	2	4
District Health Management Committee and journalist	2	District Health Management Committee and journalist	2	4
Total				16

Key informant interviews

Kurigram (Ulipur)	No. of Interviews	Sunamganj (Sunamganj *sadar*)	No. of Interviews	Total
Union UHC and Health Management Committee and member	2	Union UHC and Health Management Committee and member	2	4
Upazila Nirbahi Officer *Upazilla* Health and Family Welfare Officer	2	*Upazila* Health Management Committee	2	4
Civil surgeon	1	Civil surgeon	1	2
Total				10

Focus group discussions

Kurigram (Ulipur)	No. of Interviews	Sunamganj (Sunamganj *sadar*)	No. of Interviews	Total
Union UHC and Health Management Committee member	1	Union UHC and Health Management Committee member	1	2
Upazila health management committee	1	*Upazila* health management committee	1	2
District health management committee	1	District health management committee	1	2
COVID-19 Coordination Committee	1	COVID-19 Coordination Committee	1	2
National health veteran				1
Total				9

Select photographs from field interviews

Interview with the *upazila* Health Management Committee, Kurigram. 2022

Interview with the *Upazila* Health Management Committee, Sunamganj, 2022

Upazila Health Complex, Kurigram, 2022

Interview with the Community Clinic Committee, Sunamganj, 2022

Interview with a Naripokkho representative, Dhaka, 2023

Interview with nongovernmental stakeholders, Dhaka, 2023

Interview with the State Minister of Planning, Dhaka, 2023

Interview schedule

Name of interviewer: Date:

Name of respondent(s):

Address:

Age:

Name of the nearest community clinic:

Address:

Beneficiary (in-depth interview)

(1) Have you availed any services from community clinics in your area?

(2) When did you last visit a community clinic?

- What was the reason?

(3) Who provided you the service?

- How did you feel about the behavior of your service provider?

(4) What service did you avail when you visited the community clinic?

- What was the quality of the service like?
- Was the service to your liking? (Ask for context story)
- Do you or have you faced any obstacles in receiving treatment? (Ask for examples)

(5) What are your opinions regarding the community clinics in your area? What kind of services are provided/How do you feel about them/do you think that the support you get is enough?

- (Ask for positive/negative experiences, if any)

(6) Do you or did you ever seek healthcare services anywhere else other than community clinics?

(7) Do your neighbours, relatives, friends, etc. take or seek services from community clinics?

- Do they rely on any other sources for treatment local herbalist/healer (Shaman/ Kaviraj)?

(8) Do you have a place or a person to whom/where you can lodge complaints or voice your opinions?

(9) What steps, according to you can be taken to increase the community participation or to get people more engaged with the services they are receiving?

(10) Have you ever been the recipient of medication from this centre?

- What kind of medication?
- What was the cause?

(11) What kind of services did you avail before and after covid?

(12) What kind of services did you avail/receive during covid?

(13) Has the quality of services changed since the pandemic?

- Have you noticed any differences?
- Have you seen a change in community participation since?
- To your knowledge, were there any steps taken to increase community participation in regards to healthcare services?

District Health Management Committee and member (in-depth interview)

(1) What is your opinion on health care services at community clinics in your area?

(2) How did you join the management committee? (Story)

(3) What are the roles of your management committee in your area?

(4) How is community clinic contributing to the health of people in this area?

- What kind of services do people mostly come here to get? Why?
- What kind of problems do they mostly face while getting services? Why? (Ask for examples)

(5) Have you yourself ever taken services from community clinics?

- Why? (If not)
- What kind of service did you avail? (If yes)
- What do you think about the quality of services being offered?

(6) How do you feel about the management in these clinics?

- What are the problems or challenges?
- How can we overcome these?

(7) What steps were taken during COVID-19?

- Were they fruitful? (If yes or no then ask how and why)
- Have there been any changes in management since after COVID-19?
- What was the community participation like during and after covid? (increased/ decreased? How and why?)
- Have you noticed any changes in community participation before and after COVID-19? (Example)

(8) What is your opinion about community engagement in the management of clinics?

- What steps can be taken for more active participation?

(9) Do you generally receive support from any other outside sources/organizations?

(10) What kind of support does the government provide? (Allowance)

(11) What challenges, if any, do you face, in working in this committee?

(12) What actions have been taken to integrate or consider the voice of the public into decision making?

(13) How do you think a participatory system of governance or giving people more agency can help us deal with calamities such as a pandemic?

Journalist (in-depth interview)

(1) In your opinion, do you think that the participation of local people in healthcare services/ management is being addressed in the right manner?

(2) How is participation being ensured?

(3) Do you think participation/engagement is important at all?

- Why or why not?

NGO (in-depth interview)

(1) What are the main jobs done by your NGO?

(2) Why do you think the participation of local people in receiving clinical service important?

(3) According to you, what is the participation like of common people in health related programs?

(4) What is the participation like? If there isn't much participation, why not and what can be done to increase it?

(5) What steps have been taken thus far, to enhance the participation of local people?

- Were these steps effective? (Opinion)

Union UHC and Health Management Committee (in-depth interview)

(1) What is your opinion on health care services at community clinics in your area?

(2) How did you join the management committee? (Story)

(3) What are the roles of your management committee in your area?

(4) How is community clinic contributing to the health of people in this area?

- What kind of services do people mostly come here to get? Why?
- What kind of problems do they mostly face while getting services? Why? (Ask for examples)

(5) Have you yourself ever taken services from community clinics?

- Why? (If not)
- What kind of service did you avail? (If yes)
- What do you think about the quality of services being offered?

(6) How do you feel about the management in these clinics?

- What are the problems or challenges?
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(8) What is your opinion about community engagement in the management of clinics?

- What steps can be taken for more active participation?

(9) Do you generally receive support from any other outside sources/organizations?

(10) What kind of support does the government provide? (Allowance)

(11) What challenges, if any, do you face, in working in this committee?

(12) What actions have been taken to integrate or consider the voice of the public into decision making?

(13) How do you think a participatory system of governance or giving people more agency can help us deal with calamities such as a pandemic?

Upazila Health Management Committee (in-depth interview)

(1) What is your opinion on health care services at community clinics in your area?

(2) How did you join the management committee? (Story)

(3) What are the roles of your management committee in your area?

(4) How is community clinic contributing to the health of people in this area?

- What kind of services do people mostly come here to get? Why?
- What kind of problems do they mostly face while getting services? Why? (Ask for examples)

(5) Have you yourself ever taken services from community clinics?

- Why? (If not)
- What kind of service did you avail? (If yes)
- What do you think about the quality of services being offered?

(6) How do you feel about the management in these clinics?

- What are the problems or challenges?
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- Were they fruitful? (If yes or no then ask how and why)
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(10) What kind of support does the government provide? (Allowance)

(11) What challenges, if any, do you face, in working in this committee?

(12) What actions have been taken to integrate or consider the voice of the public into decision making?

(13) How do you think a participatory system of governance or giving people more agency can help us deal with calamities such as a pandemic?

Civil surgeon

(1) What are your opinions on the management of Community Clinics, Union Health Complexes, Sub-district Health Complexes, and District hospitals?

- What do you think about the quality of services of these institutions?
- Do you think that beneficiaries are satisfied with the quality of service they receive?
- How are the opinions of the locals reflected in terms of management of these institutions?

(2) How do you see community participation toward healthcare at union, sub-district and district levels? Are they well engaged to you opinion? If not, why? Do you think this engagement is necessary?

(3) How do you think the community is being engaged in health management committees at different tiers?

(4) Are there any policies in place to ensure community engagement in healthcare institutions?

- Do you know if these policies are being implemented?

(5) What actions have been taken to increase community participation in management levels? Do you think these steps were sufficient?

- (If not) What other steps can be taken?

(6) In your opinion, what are the hindering factors for achieving Universal Health Coverage?

- What can be done to mitigate these factors?

(7) What role do the people, union, sub-district, district level management committee members, and policy makers play in community engagement? Do you see an engagement at all.

(8) What suggestions would you make to aid/help increase community engagement?

(9) How do you think a participatory system of governance or giving people more agency can help us deal with calamities such as a pandemic?

(10) Were there any policies in place or steps taken during covid to ensure safety of citizens?

- How were the implemented? Did they help? Was the community involved in implementation?

(11) How was the community involved in dealing with a pandemic?

(12) Have you noticed any changes in terms of healthcare services or community engagement since the pandemic?

(13) What have you noticed? (If yes)

(14) Do you think that there has been a greater increase in trust among people toward medical institutions/services? Do you think there has been an increase in people availing these services?

(15) Were there any lessons learned about community engagement as we moved forward from dealing with a pandemic?

Union Health and Family Planning Officer

(1) How many community clinics are there under your supervision?

- What are your thoughts about community clinics?

(2) Have your hopes and expectations in regards to community engagement been met in the community clinic level?

- How? (If yes)

(3) What are the obstacles people face while receiving health services normally?

(4) How do you propose the situation be dealt with?

(5) What steps have been taken to ensure community engagement?

- What was the end result like?

(6) What are your thoughts on the management of community clinics, union health complexes, sub-district health complexes, and district hospitals?

- What do you think about the quality of services of these institutions?
- Do you think that beneficiaries are satisfied with the quality of service they receive?
- How are the opinions of the locals reflected in terms of management of these institutions?

(7) How do you see community participation toward healthcare at union, sub-district and district levels? Are they well engaged to you opinion? If not, why? Do you think this engagement is necessary?

(8) How do you think the community is being engaged in health management committees at different tiers?

(9) Are there any policies in place to ensure community engagement in healthcare institutions?

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(13) What suggestions would you make to aid/help increase community engagement?

(14) How do you think a participatory system of governance or giving people more agency can help us deal with calamities such as a pandemic?

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- How were the implemented? Did they help? Was the community involved in implementation?

(16) How was the community involved in dealing with a pandemic?

(17) Have you noticed any changes in terms of healthcare services or community engagement since the pandemic?

(18) What have you noticed? (If yes)

(19) Do you think that there has been a greater increase in trust among people toward medical institutions/services? Do you think there has been an increase in people availing these services?

(20) Were there any lessons learned about community engagement as we moved forward from dealing with a pandemic?

Union UHC and Health Management Committee (key informant interview)

(1) What is your opinion on health care services at community clinics in your area?

(2) How did you join the management committee? (Story)

(3) What are the roles of your management committee in your area?

(4) How is community clinic contributing to the health of people in this area?

- What kind of services do people mostly come here to get? Why?
- What kind of problems do they mostly face while getting services? Why? (Ask for examples)

(5) Have you yourself ever taken services from community clinics?

- Why? (If not)
- What kind of service did you avail? (If yes)
- What do you think about the quality of services being offered?

(6) How do you feel about the management in these clinics?

- What are the problems or challenges?
- How can we overcome these?

(7) What steps were taken during COVID-19?

- Were they fruitful? (If yes or no then ask how and why)
- Have there been any changes in management since after COVID-19?
- What was the community participation like during and after covid? (increased/ decreased? How and why?)
- Have you noticed any changes in community participation before and after COVID-19? (Example)

(8) What is your opinion about community engagement in the management of clinics?

- What steps can be taken for more active participation?

(9) Do you generally receive support from any other outside sources/organizations?

(10) What kind of support does the government provide? (Allowance)

(11) What challenges, if any, do you face, in working in this committee?

(12) What actions have been taken to integrate or consider the voice of the public into decision making?

(13) How do you think a participatory system of governance or giving people more agency can help us deal with calamities such as a pandemic?

COVID-19 Coordination Committee (focus group discussion)

(1) What are the roles of the COVID-19 coordination committee?

- What was the covid-19 situation like in this area in the last 3 years?

(2) Were civil society members and NGOs involved in the fight against covid?

- How were they involved?

(3) How has community participation helped in dealing with covid?

(4) What have we learned about community engagement from dealing with a pandemic?

(5) What actions have been taken (if any) in regards to community engagement in response to covid that can potentially contribute to community participation in healthcare post-covid?

(6) How can we better involve people, civil society members, and policy makers to achieve universal health care?

District Health Management Committee (focus group discussion)

(1) What is your opinion on health care services at community clinics in your area?

(2) How did you join the management committee? (Story)

(3) What are the roles of your management committee in your area?

(4) How is community clinic contributing to the health of people in this area?

- What kind of services do people mostly come here to get? Why?
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Union UHC and Health Management Committee (focus group discussion)

(1) What is your opinion on health care services at community clinics in your area?

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(16) How do you think a participatory system of governance or giving people more agency can help us deal with calamities such as a pandemic?

Upazila Health Management Committee (focus group discussion)

(1) What is your opinion on health care services at community clinics in your area?

(2) How did you join the management committee? (Story)

(3) What are the roles of your management committee in your area?

(4) How is community clinic contributing to the health of people in this area?

- What kind of services do people mostly come here to get? Why?
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World Health Organization

South-East Asia Region