Support to the Health, Nutrition and Population Sector Programme in Bangladesh

BMZ-No.: 2003 66 237 / 2005 70 424

Component A:
Health Financing Component

Analyses of Local Health Management Committees

for decentralized oversight, monitoring and evaluation at all levels of the health care system from each of three selected pilot districts in the present and proposed health care system

June 2012

Presented to:

Ministry of Health and Family Welfare
Health Economics Unit
Dhaka-1215
Bangladesh

KfW Entwicklungsbank
Abt. L I b
Palmengartenstr. 5-9
60325 Frankfurt am Main
Germany

FINAL REPORT

Assessment of

Local Health Management Committees

Submitted to:

Dr Lars Chr.Kyburg
Health Economics Unit
14/2 Topkhana Road (3rd floor)
1000 Dhaka
Bangladesh

Submitted by:

Research, Training and Management (RTM) International
RTM Complex (Level 3, 4 & 5)
581 Shewrapara, Begum Rokeya Sharoni
Mirour, Dhaka 1216, Bangladesh

May 2012

Assessment of

Local Health Management Committees

Contributors :

Jamil H. Chowdhury[1]

Mahboob Ul Alam Bhuiyan[2]

Md. Maruf Hasan[3]

Dr. Tasnuva Sultana[4]

[1] Director (Research and Evaluation), RTM International
[2] Consultant, RTM International
[3] Research Officer, RTM International
[4] Research Officer, RTM International

Table of Contents

ACRONYMS

AHI	Assistant Health Inspector
ANC	Antenatal Care
BRDB	Bangladesh Rural Development Board
BP	Blood Pressure
CC	Community Clinic
CHCP	Community Health Care Provider
CG	Community Group
CmSS	Community Support System
CS	Civil Surgeon
CSBA	Community Skilled Birth Attendant
CSG	Community Support Group
DD	Deputy Director
DDS	Drugs and Dietary Supplement
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Service
DSF	Demand Side Financing
EmOC/ EOC	Emergency Obstetric Care
EPI	Expanded Program on Immunization
FGD	Focus Group Discussion
FP	Family Planning
FPI	Family Planning Inspector
FWA	Family Welfare Assistant
FWC	Family Welfare Center
FWV	Family Welfare Visitor
GCM	Gram Committee Meeting (Village Committee Meeting)
GC	Gram Committee (Village Committee)
GOB	Government of Bangladesh
HA	Health Assistant
H&FP	Health and Family Planning
HEU	Health Economics Unit
HI	Health Inspector
HPNSDP	Health Population Nutrition Sector Development Programme
HPSP	Health and Population Sector Programme
HQ	Headquarters
ICDDR,B	International Center for Diarrheal Diseases Research, Bangladesh
IDI	In-depth Interview
IMCI	Integrated Management of Childhood Illness
INGO	International Non-Government Organization
JICA	Japan International Cooperation Agency
KFW	German Development Bank
KII	Key Informant Interview
LHMC	Local Health Management Community
LLP	Local Level Planning
MA	Medical Assistant
MCH	Maternal and Child Health
MCWC	Maternal and Child Welfare Center
MDG	Millennium Development Goal

MMR	Maternal Mortality Ratio
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
MP	Member of Parliament
NGO	Non-Government Organization
OH	Our Health
ORT	Oral Re-hydration Therapy
PNC	Postnatal Care
PRA	Participatory Rapid Appraisal
PRDP	Participatory Rural Development Program
RMO	Resident Medical Officer
SACMO	Sub-Assistant Community Medical Officer
SMPP	Safe Motherhood Promotion Project
SSK	Shasthyo Shurokhsha Karmasuchi
UCC	Union Coordination Committee
UCCM	Union Coordination Committee Meeting
UDO	Union Development Officer
UFPO	Upazila Family Planning Officer
UHC	Upazila Health Complex
UHFPO	Upazila Health and Family Planning Officer
UHFWC	Union Health and Family Welfare Center
UHMC	Upazila Hospital Management Committee
UNICEF	United Nations Children Fund
UNICEF	United Nations Children Fund
UNO	Upazila Nirbahi Officer
UP	Union Parishad
VHP	Village Health Post
WHO	World Health Organization

Executive Summary

The government of Bangladesh has decided to launch a health protection scheme known as Shasthyo Shuroksha Kormasuchi (SSK) in Tungipara of Gopalgonj district, Rangunia of Chittagong district, and Debahata of Satkhira district. It has been felt necessary to study the various health related situations in the pilot upazillas. The Assessment of Local Health Management Committees is one of those studies. The study was carried out during April-May 2012 to assess the capacity of the Health Management Committees and propose specific interventions for strengthening them for successful implementation of SSK pilots.

The study team visited three proposed pilot upazilas and also three other ongoing pilots such as Chowgacha, Narsingdi and Chokoria to conduct in-depth interview, FGD and few key informant interviews.

The study found that although local level committees centering the Community Clinic (CC) were mostly functioning, they were not functional as expected. Only where local Committee leader was strong it made a difference. One of the important strengths of the committee is that all the members are local and they live within the periphery of the CC. One serious weakness of the CC committee is that meetings are not held regularly and routinely and all members do not remain present in all meetings.

There is no health management committee at any of the unions visited. There is however an FP committee which is not effectively functioning except in cases where the UP chairman is interested. It is the only Union level Committee (Union Family Planning Committee) where all local government representatives are its members. As committee members, they have not received any training or orientation on the programmatic issues, and as such there remain some knowledge gaps inhibiting their full contribution.

There is no evidence to show that top imposed Upazila Hospital Management Committee formed at the upazila level is effective or functional. The committee is too large to be effective. However, as the committee is constituted by office order of MOHFW, there is ample opportunity to utilize the services of human resources in health, infrastructure, medicine and health equipment locally for the welfare of the local people. There is neither any representation of union and local community level H&FP personnel nor of the local government representative from the UP level. For that reason the problem of grassroots level are not likely be properly addressed.

The SSK model should emulate the CSG from Narsingdi community model as it is purely a local community initiative with the record of local resource mobilization. Moreover, it has already been decided by the government in CC revitalization that each CC should have threeCommunity Support Group (CSG) in the periphery. Chowgacha model, on the other hand should be reviewed for adopting the upgradation and strengthening of Upazila Health Complex.

The following recommendations are considered worthwhile for strengthening the role of local committees for SSK pilots:

- The committee could be involved in the participatory process (PRA) of identifying the poor, the local level problems and for raising awareness in SSK programme.
- Orientation should be provided to all committee members and staff to build their capacity for the successful implementation of the process, objective and modality of SSK.
- The monitoring role of the community members should be strengthened for ensuring the quality of service and better provider accountability.

Section 1: Background and Objectives

1.1 Background

The Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MoHFW), Government of the People's Republic of Bangladesh, has been taking various efforts for improvement in the areas of health financing/health economics and equity especially designed to assist the poor and achieve the target of Millennium Development Goal. Under the leadership of HEU/MoHFW discussions have been conducted with key stakeholders and policy makers for the identification, design and implementation of one such health financing pilot in selected areas. The pilot has been conceptualized as a social health protection scheme termed SHASTHYO SHUROKHSHA KARMASUCHI (SSK). The SSK model has been developed with input from experts from many workshops, meetings and seminars over a period of two years. The German Development Bank (KfW) and GFA Consulting Group from Germany have been providing assistance to the project. It has been agreed that the ultimate aim of the project is to create a national health insurance scheme (health protection scheme) to be known as SSK.

The SSK project aims to i) Improve access of the poor to hospital inpatient care by reducing financial barriers, ii) Decentralize hospital activities for functional improvement in the health sector in phases as a part of Local Level Planning (LLP) and development, and iii) Introduce modern Information and Communication Technologies for increased efficiency and transparency in the health sector (e. g. claims processing, accounting, controlling and electronic patient records).

The health financing pilot will ultimately investigate new sources of financing for the health care system in Bangladesh. Such sources may include introducing compulsory/voluntary health insurance for the entire population and health insurance premiums. The pilot will also test mechanisms to improve the quality and increase demand for health services. The proposed studies will inform the design of the pilots by providing preliminary analyses of local health care management committees for ensuring local participation to promote ownership in health care system.

1.2 The need for SSK

The **Health Population Nutrition Sector Development Program (HPNSDP) 2011-2016** clearly articulated as one of its goals to "ensure quality and equitable health care for all citizens by improving access to and utilization of health, population and nutrition services (P:5 Strategic Plan, HPNSDP)" . The development objective in order to achieve this goal is to improve both access and utilization of such services, particularly for the poor.

The Sixth Five Year Plan (2011-2015) also reiterated that in rural areas HPN sector's financing will be raised through cost sharing by well-to-do patients when they are treated in public

hospitals. Moreover, the government will encourage promotion of Health Insurance Pilots at different levels (P: 366, Part 2).

The National Health Policy 2011 has pledged to solve the problem of health financing in health sector, it is needed to introduce health insurance in the formal sector. But in phases, the insurance program can be extended to other sectors. It is necessary to ensure free health care for the very poor and disadvantaged population. GoB will provide health cards for the poor in a recognized adapted way (P:9, Strategy 19).

The goal of **Health Care Financing Strategy** (which is still in the process of development) as delineated in its first draft is to strengthen the financial risk protection, and extend health services and population coverage, with the aim to achieve universal coverage.

Vision 2021 has also articulated the need for modern and adequate social health insurance that could mitigate the costs to the individual, family and society.

1.3 Goal and objectives of the study

Before launching of the SSK pilot project in Tungipara of Gopalgonj district, Rangunia of Chittagong district, and Debahata of Satkhira district, it has been felt necessary to study the various health related situations in the pilot upazillas. Various studies have been undertaken and "The Assessment of Local Health Management Committees is one of those studies. The study was carried out during April-May 2012.

The prime goal of the proposed study is to assess the existing state of Health Management Committees, identify their strengths and weaknesses, and place recommendations for strengthening their role, functionality and participation in the implementation of SSK pilots.

Objectives of the study

The prime goal of the proposed study is to assess the capacity of Health Management Committees and propose specific interventions for strengthening them for successful implementation of SSK pilots. However, the specific objectives of the proposed study were:

- to explore and understand the role and responsibilities of the local health care management committees existing at all levels of the health care system in one Upazila from each of the selected districts
- to explore the constraints or problems that prevent the committees from functioning effectively and efficiently
- to review local participation in relevant health sector pilots, even if it is located outside the selected pilot districts
- to explore how local health care management committee would impact health care utilization at public health care facilities to meet the needs of proposed National Health Protection Scheme and Results Based Financing
- to determine if and how management committees can be considered as an effective instrument for future community participation in respect of planning, budgeting and monitoring elements of social health insurance and health financing

Section 2: Methodology

2.1 Approach and design

The study was purely a qualitative one following a cross-sectional design and drawing information from both primary and secondary sources. The study design aimed to collect data through in-depth review of past and present health care management committees and also to explore a proposed model for such committees for future implementation. The study has tried find out a model for community participation through the local health care management committee in respect of planning, budgeting and monitoring elements of social health insurance and health financing.

2.2 Methods and techniques

The three pilot upazilas selected for the SSK pilot programme were the study area. The study collected data from respondents at three service delivery tiers within upazila, specifically at upazila (including UHC), union (including union Sub-center or Rural Dispensary (RD) or Union Heath and Family Welfare Centre (UHFWC), and community level (including community clinic). In each upazila, three unions (sadar union, one union within 4-8 km from upazila headquarters (HQ) and another union more than 8 km far from upazila HQ) were selected and from each of the selected union one Community Clinic (CC) catchment area was selected for the study. Altogether, the study covered three upazilas, nine (3 unions x 3 upazilas) unions and nine (1 CC area x 9 unions) CC areas in the selected pilot districts. In addition to these Civil Surgeon (CS), Deputy Director (DD) at the district level and Directors (both H&FP) at Divisional level were included for open discussion.

Outside the SSK pilot areas, three other pilot projects were visited by the research team to investigate and explore what elements were responsible for drawing the attraction of wider audience for the claimed success of those pilots and what lessons could be adopted for the SSK program. The three successful pilots included Chowgacha in Jessore, Narsingdi Sadar (JICA supported project) in Narsingdi district and Chokoria (ICDDR,B project), in Cox,s Bazar district. The study also reviewed the activities of the LLP program in Satkhira district.

The study used qualitative methods such as in-depth interviews (IDI), key informant interviews (KII), and focus group discussion (FGD). The in-depth interview of health program personnel was done at all the three levels. At the community level, field staff such as Health Assistant (HA) and Family Welfare Assistant (FWA) and Community Health Care Provider (CHCP) attached to the CC were interviewed. At the Union level, field staff and clinic staff from both Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) were interviewed. An in-depth interview guideline was used to capture individual views about their roles and responsibilities in committees, constraints and problems of its functioning, impact of committees on health care utilization, and recommendations for future community participation.

In the three other outside pilot areas key informants who were involved from the beginning of the project and who knew the history of success very well were interviewed. At least two such key informants were interviewed in each successful pilot. Interviews with them focused on community participation component in order to explore their experience in local participation in

the project areas. In each area either an FGD was conducted or more in-depth discussion were held with project or hospital staff, volunteers and patients reporting for service. Subject to availability and considering their usefulness, informal open discussions were also carried out with Upazila Nirbahi Officer (UNO), Upazila Chairman and Union Parishad (UP) Chairman in some successful pilots.
The following list exhibits the number of respondents for IDI, KII and number of FGD sessions by category of respondents:

Key Informant Interview		In-depth interview		FGD session	
Successful Project Officials	6	UHFPO	3	At upazila level	3
Divisional Level	6	UFPO/MO(MCH)	3	At union level	9
District Level	6	RMO	3	At CC area	9
		HI	3		
		AHI	9		
		FPI	9		
		MO	9		
		MA	9		
		FWV	9		
		CHCP	9		
		HA	9		
		FWA	9		
Total	**18**	**Total**	**84**	**Total**	**21**

In addition to the above, three successful pilots were visited and 2 KII, two FGDs and discussion meetings were held with other stakeholders such as nurse, Medical Officers, UNO and Upazila Chairman and a few patients who visiting the facility for service on the day of visit.

2.3 Limitations of the study

One major limitation of this study is that it was a rapid assessment of the committee functions, based on the opinion and perception of providers, committee members. There is likely to be some bias in many of the responses related to the functions of the committees. Had there been some opportunities to observe the holding of meetings of one or two committees, and also the activities they perform, the result could have been a little different. Another serious limitation of this assessment is that the study respondents and even the committee members all represented the supply side in the context of the study. No information was collected from the beneficiaries or from the demand side. The opinion and perception of the real beneficiaries were not available for validating the findings.

Section 3: Local Committees at different levels and their roles and functions

3.1 Existence and functional status of the committees at the community level

Does a committee exist at the community level? Across all the pilot upazilas the responses were positive. Although at the community level a committee exists centering around the community clinic (CC), nowhere it is known as Local Health Management Committee. It is sometimes named after the name of the CC, or Community Support Group or Health and Family Planning Management Committee. Interestingly in Debhata of Satkhira district it is commonly known as 'Community Clinic Management Committee'. As seen from the different names in different areas, there is no common given name for the local CC management committees. Formulation of these committees is more or less guided by the policy guideline for establishment of community clinic.

The committees generally comprise UP member, land donor, UP Chairman, religious leaders, local elites, landless farmers, school teachers, freedom fighters and social workers. CHCP, HA, FWA are non-voting members. It is seen that in every committee there are more than one representative from local government. As per government policy guidelines of the establishment of the community clinic committee has to be formed with 7-9 members with minimum 2 female members and any of the above listed community group. But this policy guideline regarding the size and composition has been revised in 2011. Now, the size is of 15-16 members and the respective UP Ward member should be the Chair of the committee. Formerly the landowner used to hold the position of the Chairperson, but the new circular has stipulated that the land owner should be the Vice Chairperson of the committee.

In none of the upazilas a manual was available detailing roles and responsibilities of committee Although Policy guideline for the establishment of community clinic in the 'Responsibility of Community Group' (subsection 4.3.2) has indicated some roles and responsibilities, yet those were not by individual portfolio but as a committee in general. Most of the respondents seemed not to be aware of roles and responsibilities

In all the three upazillas the common response regarding the holding of the meeting was that in most places the meetings were held quarterly. Although respondents at the community level reported that the meetings were routinely held, it could not be supported by any substantial evidence such as a copy of the resolution. Probably meeting resolutions are not also properly recorded suggesting that meetings were not probably effective. It was reported that many of the CC activities remained suspended during the previous regime. The operations and functioning of these CC level committees resumed after the Awami League Government took power in 2009.

There is no established or fixed system for notification of the meeting and follow-up. The usual practice for calling a meeting is to inform verbally or through cellular phone. Although most of the respondents claimed that most members remain present in most meetings, no attendance register was available to validate their claim. It suggested that meetings were not systematically held.

There is no fund to compensate the time of volunteers who attend the meetings. There is no provision or fund for payment of incentive or any kind of allowance. There is also no fund for refreshment of the attendees. Entertainment is usually self contributory. This lack of incentive or

any fund for refreshment may work as disincentive not to attract members to attend the meetings regularly.

The most common agenda in these meetings include awareness raising regarding health service, client motivation, development of community clinic and health service, availability of medicine, maternal and child health, EPI, motivation of clients to visit CC, performance review of field staff and cleanliness, Beyond the common agenda respondents in Tungipara upazila informed that they also discussed prevention of early marriage and dowry, DSF program, information dissemination etc.

Regarding the system of follow up of the meetings it was reported that the progress was reviewed in the next meeting and President of the committee taking personal initiative was the common practice. All the respondents did not say that there was a system of follow up leaving room for doubt that there indeed was any system of follow up.

It is very important to note that government has revised the composition of the CC management committee and has decided to integrate the Community Support Group (CGS) System. The composition of the Community Group and the Community Support Group as per the latest government manual would be as follows

Table 3.1: Community Group (CG) Structure:

Sl	Post held by Committee Members	Number	Selection Procedure	Remarks
1	Chairperson	1	Union Porishad (UP) member of the ward of Community Clinic(CC)	1. One of these three members must be a female representative 2. The land donor or his representative will be the only lifetime member
2	Co Chairperson	2	One is the land donor or his nominated representative and another is selected among the members.	
3	Treasurer	1		
4	Member Secretary	1	Community health care provider and non voter member	He will provide all kinds of official support to the community group
5	Observer Member	11-13	Selected from the beneficiaries	Non voter member
	Total	15-16		

3.1.1 Functions of CG & selection process of members

- The 1st meeting of the CG called by the chairman of the concerned UP must be held within 30 days after formation. In this meeting the responsibilities and duties of the committee members will be determined upon discussion and consensus of the committee.

- The selection/election of the Chairperson, Co chairperson, Member Secretary and Treasurer will be completed in the first meeting in the presence and supervision of the UP chairman

Major Functions and Responsibilities of the CG:

- Ensure Safety of the Community Clinic
- Cleanliness of the community clinic
- Day to day maintenance of the clinic
- Long term maintenance
- Prepare annual working plan through problem and resource identification, collection of information in the working zone of community clinic
- Formation of support group
- Motivate the people about the community clinic
- Raising fund for community clinic
- Holding regular monthly meeting
- Communication and coordination between the community, service providers and managers

Table 3.2: Community Support Group (CSG) Structure

Sl	Post held by Committee Members	Number	Remarks
1	Convener ***	1	Any one from Convener and joint convener should be female
2	Joint Convener***	2	
3	Member Secretary***	1	
4	Executive Member	9-11	
	Total	13-15	

*** While selecting the Convener, Joint Convener and Member secretary priority is given to the person who knows effective computer operation

3.1.2 Functions and Responsibilities of the CSG & its Members

- The 1st meeting of the CSG must be held within 30 days after its formation. In this meeting they will decide their responsibilities and duties as per discussion and at the same time they will assume their duties with immediate effect and give commitment to discharge their responsibility.

Major Functions and Responsibilities of the CSG:

- Core Responsibilities of the Members of CSG
  - Regular coordination with CG
  - To lead CSG effectively
  - To create awareness among the beneficiaries on maternal and child health , nutrition and FP methods and about the services provided especially from the community clinics
  - Timely refer the critical cases to the higher level facilities
  - Helping to create fund for CC by mobilizing local resources

- Utilizing the local fund for maintenance of community clinic and for helping the very poor and disadvantaged for emergency medical care.
- There will be general meeting of the CSG in every two months. Member secretary will convene the meeting with approval of the chairperson

Key findings:

- CC committees are functional in most places but whether they are effective remains a big question except in cases where the local leader takes the initiative.
- Many of the CC committees are functioning because government has taken special interest and CC is a priority project of the MOHFW.
- There is no proper manual available at the committee level to understand who should play what role.

3.1.3 Strengths and weaknesses of the community level committees

Strengths:

1. All the members of the committee are local and they live within the periphery of the CC.
2. The land owners who have donated land have the full ownership and take various initiative for holding meeting and continuation of services.
3. As the local health and Family Planning (FP) workers are members of the committee they could work to raise awareness of the local community and extend technical knowledge and support to the committee members
4. Since all the members of the committee are local, they know each other and can easily communicate and coordinate about routine and emergency issues.
5. In case of some committees local UP members and UP chairmen as the community leader sometimes influence the functioning of the committee
6. Local elite having influence on the local people can raise awareness for facility utilization
7. Local committee can take initiative to solve the problem of the facility through local initiative

Weaknesses:

1. Meetings are not held regularly and routinely and all members do not remain present in all meetings.
2. Meeting resolutions are not in most cases properly and systematically recorded and followed up.
3. In general there is no initiative for local resource mobilization
4. In most cases committees do not play any monitoring role to ensure whether providers are providing regular and timely services
5. Since there is no formally defined role of different members, sometimes it is not clear to the members who should do what.
6. There is no systematic or proper planning for facility utilization, logistics procurement and awareness raising

3.2 Existence and functional status of the committees at the Union level

Although everywhere a local committee exists for the community clinic there is no committee at the union level under the DGHS that comprise local community. The only committee that exists at the Union level is commonly known as Union Family Planning Management Committee. It is clearly understood from the responses of respondents in all the three pilot areas that there is no health related committee at the union level. The agenda of FP committee that has existed for long is related to population and FP service delivery and MCH which was always a part of FP service. The Union FP Management Committee comprises the following members:

Table 3.3: Composition of Union Family Planning Committee

Sl	Post hold	Position in Committee
1	Chairman, Union Parishad	Chairperson
2	Member, Union Parishad (all)	Member
3	Union Level Officials (all)	Member
4	Head Master/Teachers/Principals from 1 selected 1 Primary school, 1 boys high school, 1 girls high school and one college (if available) within the union (nominate by the Union Parishad)	Member
5	Ansar Commander	Member
6	President, Union Imam's Society	Member
7	President, Union Kazi Society	Member
8	One representative from any NGO working for family planning (nominate by the Union Parishad)	Member
9	President of local mother's club/Women's society/Cooperative society	Member
10	Sub-Assistant Community Medical Officer	Member
11	Family Planning Inspector (female)	Member
12	Family Planning Inspector (male)	Member Secretary

3.2.1 Functions of the Committee

1. The committee will:

   a. organize union based programs, fix target, evaluate achievement in the monthly meeting and take necessary steps after the evaluation in the meeting and forward problems and recommendations to the Upazila committee
   b. evaluate and supervise the activities of individual workers at union level and take remedial action for the failure and negligence in the work
   c. take necessary action for the improvement through motivation meeting/seminar/courtyard meeting discussion addressing the less developed area, slum, Char, remote and hilly areas to disseminate family planning activities and health issues of mother and child
   d. arrange a motivational meeting along with the representative of teachers, Imam, Kazi and local elites for building awareness regarding family planning and health of mothers and children

e. take initiative to form a Village committee chaired by local member of the Ward committee or any respectable person
f. evaluate the overall management and the progress of work of the community clinic within the Union
g. take initiative to form local mother's club/Women's society/Cooperative society and coordinate the family planning and mothers and child health program
h. actively take action and coordinate and evaluate the work of community based voluntary project within the union

2. The Secretary of the UP will provide support and assistance in the execution of routine work of the Committee
3. If necessary the committee will co-opt the influential respected, educated or religious person as the member of the committee

Key findings:

- There is no health management committee at the union level anywhere
- Union level FP committees are generally not functional except in cases where UP chairman takes personal interest.
- Union FP committee only reviews progress of work of the field personnel regarding family planning

3.2.2 Strengths and weaknesses of the Union level committee

Strengths:

1. It is the only Union level Committee (Union Family Planning Committee) where all local government representatives are members of the committee
2. The monthly performance of the Union level field personnel is reviewed by the Union level local government representatives (UP Chairman and members) and as such has a system of accountability to the people.
3. In some cases the local UP chairman with personal drive can make these committees functional.
4. In some cases UP chairman takes the ownership and physically inspects the receipt of DDS kits to check the quantity of drugs and other supplements available thus establishing a system of accountability.
5. UP members and chairman sometimes participate in motivational campaigns organized for increasing the acceptance of FP methods.

Weaknesses:

1. Meetings of these committees are not held regularly and as such continued follow up of decisions becomes difficult.
2. Resolutions are not recorded in most cases and as such it becomes difficult to track implementation status and follow up the decisions
3. Local government representatives have no administrative control over the government staff and as such cannot take any action for non-compliance

4. As committee members do not receive any training or orientation on the programmatic issues, there remains some knowledge gaps inhibiting their full contribution.
5. Since there is no financial incentive for attending committee meetings, members do not feel encouraged to attend meetings regularly as they do in case of other development programmes where there are tangible benefits in cash or kind.

3.3 Existence and functional status of the committees at the Upazila level

At the Upazila level a committee exists centering around the upazila health complex, but nowhere it is known as Local Health Management Committee. There is an upazila health complex based Health Committee known as Upazila Hospital Management Committee (UHCM). This in fact is an advisory committee. This committee was formed following a circular from the Hospital-2 Section of the MOHFW issued on 05-04-2009 substituting the same memo and date (Memo- Hosp-2 / Inspection Committee-1 / 2007 / 193). This is a 21 member committee and the local Member of the Parliament is the Chair of this committee. The other members of the committees are Upazila Chairman, Vice Chairman, UNO, Upazila Health and Family Planning Officer, RMO, Local male elites, female elites, upazila Officer in charge (OC). It is just a paper based committee. The following table shows the composition of the UHMC.

Table 3.4: Upazila Hospital Management Committee (UHMC)

Sl	Position held	Position in Committee
1	Concerned Constituency Member of .Parliament (MP)	Chairperson
2	Chairman (Elected), Upazila Parishad	Vice Chairperson
3	Upazila Nirbahi Officer (UNO)	Member
4	Mayor, Pourashava (If available)	Member
5	One Female Vice Chairman, Upazila parishad	Member
6	Officer In charge , Police Station	Member
7	Upazila Social Welfare Officer	Member
8	Resident Medical officer (RMO), Upazila Hospital	Member
9	Medical officer (MCH)	Member
10	Upazila Family Planning Officer (UFPO)	Member
11	Nursing Supervisor, Upazila Hospital	Member
12	Councilor, Pourashava (If available)	Member
13	Representative from Upazila Muktijodha command council	Member
14	Union Parishad Chairman (Female) or nominated by UNO	Member
15	NGO Representative nominated by UNO	Member
16	President, Press Club (If available)	Member
17	One eminent member from Civil Society	Member
18	Representative from Nursing (Concerned Organization)	Member
19	Representative 3rd class employee (Concerned Organization)	Member
20	Representative 4th class employee (Concerned Organization)	Member
21	Upazila Health and Family Planning Officer (UHFPO)	Member Secretary

3.3.1 Functions of the UHMC

Nowhere was the committee evidenced to be fully functional. As it is not fully functional, in most places meetings are not held properly and regularly. The other reason is that as the local MP is the Chairperson who remains in the capital city most of the time, meetings are not held regularly in his absence. In rare cases it was reported that he requested the Upazilla Chairman to chair the meetings. It is an entirely different committee than any Local Health Management Committee. In this committee there is no involvement of local people except the elected representatives (UP Chairman, Upazila Chairman). So there is no local level participation of the general people. It is indeed an upazila health complex committee. The activities are not similar as it should be with a Local Health Management Committee. The main constraint that prevents the committees from functioning effectively and efficiently is the non-attendance of MP and other members of the committee. The involvement of MP who stays most of the time in the capital city has not been effective as he cannot make himself regularly available to attend the meeting because of many other preoccupations. It would be better if the MP nominated the upazila chairmen to act on his behalf and chair all the meetings. As this committee was designed with a top down approach (following a circular from the MOHFW) without any bottom level initiative, this has already started to prove ineffective.

The functions of the UHMC as per the government circular are as follows:

1. The Member Secretary may convene a meeting subject to approval of the Chairperson
2. The committee should meet at least once a month
3. The committee may co-opt maximum three members with priority to co-opt female members
4. Seven members will form quorum in the meeting
5. The committee will take actions on priority basis to improve the quality of services (preventive& curative) of Upazila hospital and ensure that services are specially received by valiant freedom fighters, extreme poor, women and children, and the disadvantaged group.
6. The committee can mobilize, preserve & utilize resources locally as well as ensure the proper utilization of resources allocated by the government (human resource, medicine, equipments, furniture, and infrastructure etc.)
7. The committee should take initiative to adopt annual plan and ensure its implementation as per approved budget of the concerned hospital.
8. The committee may select sub-committees from among committee members & outsiders to discharge special responsibilities for any specified period when needed.
9. The committee will coordinate, monitor, and observe the activities of upazila hospital and other facilities under its jurisdiction.

Key findings:

- There is no evidence that Health Management Committee imposed from the top is effectively functional
- There is neither any representation of union and local community level H&FP personnel nor of the local government representative from the UP level
- Health and FP performance are in general discussed in monthly upazila coordination meeting chaired by UNO and as such any other committee meeting at the upazila level gets little importance

3.3.2 Strengths and weaknesses of the Upazila level committee

Strengths:

1. As for the committee constituted by office order of MOHFW, there is ample opportunity to utilize the services of human resources in health, infrastructure, medicine and health equipment locally for the welfare of the local people.
2. As the committee is represented by local elites, public and elected representative and local level officers of various sectors experienced in local level planning and implementation of Government resources, it could mobilize and procure additional funds required for continuation of services and sustainability.
3. As a result of the discussion of the problem in the meeting the actual and accepted solution come out which ultimately helps to take participatory decision.
4. The committee has the authority to ensure the presence of all health staff in duties timely and effectively due to unanimous decision of the committee.
5. As the committee is chaired by Member of Parliament (MP) of the local constituency apparently by nature the committee is powerful. Due to his bargaining power in the policy level he can easily procure local as well as government funds resulting in strong output.
6. The authority of theses committee to create a sub-committee from among committee members & outsiders may be an effective way to involve them from special projects

Weaknesses:

1. The UHMC is called an advisory committee and as such it may not get involved into the day to day implementation details.
2. The committee comprises 21 members which is too large to be effective in many aspects.
3. There is neither any representation of union and local community level health and FP personnel and stakeholder nor of the local government representative from the union level. For that reason the problems of grassroots level may not be properly picked up and discussed.
4. There is neither any specific budget allocated for refreshment nor any honorarium for attendance for which some of the members may not give priority to attend the meeting.
5. This meeting generally does not allocate any resources rather it gives guidelines on the basis of the discussion in the meeting. The committee has no administrative power to solve problems rather it can suggest the solution through discussion.

Section 4: Lessons from some other pilots

4.1 The Chowgacha Model

Although the Government hospitals all over the country present a grim picture of poor services, poor management and mis-governance, Chowgacha has made a difference. Chowgacha model, however, is not purely a local health management committee and the key its success does not fully depend on it. Here Chowgacha is a upazila of Jessore District. Here the initiative was taken by the facility managers and service providers, some doctors at the Chowgacha Upazila Health Complex (UHC), who were committed to develop a health service facility model primarily for maternal and child health services. They had been able to engineer community participation and mobilize community support when the community realized that everything they did was for the interest of the local community and not for the interest of doctors and staff working at the health complex. The activities of Chowgacha model started as early as 1985. The idea of developing a model health service delivery point was first conceived by Dr. Abdul Mannan, who was the then Upazila Health and Family Planning Officer (UHFPO), the chief executive, of the sub-district level health facility known as Upazila Health Complex (UHC). The dream of Dr. Mannan was carried over by his colleagues, most specifically Dr. Md. Emdadul Haque who has been working as Gyane and Obstetric Consultant in the health complex. He was strongly supported by other colleagues, most specifically by Dr. A.S.M Abdur Razzaque, Resident Medical Officer, who hails from the same upazilla and his wife Dr. Selina, a gayenocologist. All these doctors have long been working in the same hospital and never desired a posting or transfer outside. Some were fully committed to serve the people of their own locality while others worked to sustain the model and they were therefore all for it.

The philosophy that worked behind the growth of this model was the motivation of doctors for maximum utilization of government resources with honesty and sincerity, providing effective and prompt services through improved management system and showing respect to the patients. The most important step in steering the model to its right track was to make the hospital free from all types of corruption. There are a few elements of corruption that commonly plague the public health facilities at the sub-district level. These are issuing of medical certificate in favour or against different disputing groups or individuals that make an opportunity for the doctors to earn money, chamber practice by the facility doctors, charging unauthorized fees for pathological or radiological tests, or pilferage of government supplied medicine meant for the poor patients. The doctors and the staff came to consensus to eliminate all these elements of corruption to make the hospital a patient friendly one. Establishing good governance worked like a magic. The good image created not only attracted more patients but also drew the favours of local community, local elites and local affluent people willing to support the initiative by offering financial and other resources. The doctors also mobilized renowned and influential individuals for providing emergency life saving drugs for poor patients. They also convinced the Medical Representatives of 20 pharmaceutical companies to supply one piece of injection to the hospital. Local community leaders especially the UP chairmen strongly supported the efforts of these doctors and offered to pay the honorarium of 46 female volunteers recruited to work against the vacant positions of government field staff, increase doctor nurse ratio and receive the services of other staff such as volunteers, cleaners, and guards required to tackle the excessive flow of indoor and outdoor patients. Local administration and Upazila Parishad also extended all possible support to the hospital management. These are all community support extended to make

the Chowgacha model a success and the key to sustain the model has been the combined effort of health management, local administration and community leaders.
Encouraged by the various initiatives taken by the UHC management, Chowgacha started receiving technical and logistic support from DGHS and various international organizations such as JICA, UNICEF, and WHO. From January 1995 to 1998 JICA provided assistance to streamline the Frontline MCH Program. From December 1999 Reproductive Health Unit of DGHS and UNICEF provided human resource development and logistic support. Comprehensive EOC services was started in November 2000 and in August 2006, Safe Blood Transfusion Unit was established with the help of UNICEF. Chowgacha UHC is also a women friendly hospital. In April 2007, demand side financing (DSF) program was started there. Chowgacha UHC received national awards in 2004, 2005, 2006, 2008, 2009 and 2010. It was on 20th June 2008, that Chowgacha was declared as model health complex and upgraded to 50 bed hospital by the Secretary MOHFW. Dr. Margaret Chan, Director General, WHO visited Chowgacha in 2010 and recommended the replication of Chowgacha Model throughout the country.

Some of the activities of this hospital overwhelm the activities of some other famous health service provider organization in the country in terms of bed occupancy (which was rated more than 207 percent in 2011), institutional delivery, caesarian section, number of ANC visits, maternal mortality, newborn and infant mortality etc. Some of the special initiatives of the UHC include the creation of an ANC corner, issuance of card to each women coming for first ANC visit, round the clock Emergency Obstetric Care (EmOC) service, maintaining criteria of women friendly hospital, cellular phone in emergency, indoor and EOC to provide telephonic health service facility and emergency ambulance service, a blood bank system run by 850 registered blood donors living within 1 km radius of the hospital, reception center desk managed by volunteers, community support received for ANC card, blood grouping reagents, generator fuel, salary of 50 volunteers, IPS and furniture, ambulance tyres etc., birth and death recording system in a specially developed format, and indoor service monitoring, patient satisfaction monitoring system and 12 years of information recording system.

When one enters the premises of Chowgacha UHC one will feel the visible difference why Chowgacha is so very different from any other UHC in Bangladesh. One does not only see a beautiful and well distempered hospital building but will also find out that:

1. There is a separately marked area for parking of vans, motor cycles and bicycles and presence of security guard at the entrance to prevent the entrance of cows, goats etc.
2. Beautiful, neat and clean environment is being maintained by keeping the premise well swept and road side gardening.
3. Beautiful Ayurvedic gardening with name plate of 64 types of trees used for recreation of patients and attendants.
4. Well decorated infrastructure of the hospital with separate residential campus.
5. Citizen charter of hospital and field services displayed on the wall of the hospital.
6. Protocol board to locate the service points.
7. Separate ANC corner, EPI corner, ORT corner, IMCI corner etc.
8. Separate service delivery system with 4 outdoor patient registration counters
9. Continuous health education sessions at outdoor, indoor, ANC registration room conducted by senior level health service providers. At the outdoor these sessions are also intended to make the village women and the attendants who come with them aware about how to take services in the hospital and the process of cleanliness and the hygiene of daily life.

What is the visible impact of the success of the model? One will easily recognize from the flow of patients especially coming for ANC and delivery care. Some are visiting from long distance and from other neighboring sub-district and have deliberately avoided going to the district hospital as they perceived service in this UHC was better. Talking to some ANC patients to understand their perception about the services of the hospital, the general opinion of one to all as understood from their reactions was of great satisfaction expressed in terms of 'this hospital provides free service', 'we never go back without taking service', 'providers behave very well' 'doctors in other hospital get annoyed if a question is repeated' and 'will recommend other to visit this hospital'.

The impact of the model on the overall health indicators as recorded by the hospital management is enormous. Chowgacha has achieved MDG 4 and 5 goals. In 2011, the maternal mortality ratio (MMR) in Chowgacha was 68/100000 live births as against the national average of 194. The neonatal, infant and under-five mortality rates in Chowgacha are 18.7, 23.6 and 25.7 per 1000 live births respectively and the corresponding national averages for all these rates are 28, 39 and 50.

Lessons learnt from Chowgacha model:

- Several attempts have been made to replicate the Chawgacha model but no evidence of success has yet been recorded. So, this cannot perhaps be an easily replicable model.
- If the hospital is made free from corruption and staff are committed to create a patient friendly environment, this can bring a great change with marked increase in facility utilization.
- Staff, especially doctors, has to be retained for long without transfer to make any such pilot successful.
- There is some leadership behind every success, and Chowgacha has made the success because of the committed and selfless leadership of the facility Managers and Providers. One key element of success is that some of the doctors working in the hospital are from the same locality who take ownership and pride about the success.
- GOB funding alone cannot solve all the problems and funding constraints always stands as a barrier for good services. In Chowgacha this barrier was removed by optimum and planned utilization of the existing resources, mobilization of resources by local elites, public representatives and financially sound philanthropic minded people. Also mobilization of various development partner supports was instrumental to sustain the success.

4.2 JICA supported Narsingdi Model

Considering the high level of maternal health complications and high maternal mortality ratio in the country Government of Bangladesh has been taking various efforts to improve the maternal health situation in the country. It has been evidenced that in Bangladesh only one-third of women who suffer from obstetric complications present themselves to medical facilities. It has been strongly advocated for the last several years that the management of the obstetric complications at facilities needs to be increased to avert more deaths. The complications arise suddenly leaving no time for preparation and as such require prompt action. Sometimes the family of the victim is unable to take decisions or do not have the financial and other means to

do it. If there is a collective and proactive community support for timely shifting these women to the facility, many more maternal lives could be saved. In the backdrop of this situation, the Government of Bangladesh initiated a pilot project named Safe Motherhood Promotion Project (SMPP) in 2006 in Narsingdi district.

The design of the SMPP pilot required to test a community led approach for establishing collective community actions known as Community Support System (CmSS). The process of forming CmSS includes community diagnosis using qualitative methods such as PRA, case studies, in-depth interviews etc. The steps in establishing an active community support group involve, 1) identification of tragic and avoidable incidences related to maternal health; 2) Identification of proactive leaders in the community; 3) Mobilization of local resources; and 4) Making the resources available to the women in need in future. At the beginning the capacity of the identified leaders on participatory facilitation process is developed. Community meetings are organized where case studies are shared and analyzed to identify underlying causes of maternal deaths. Through this process, community people recognize the need of collective actions to support women especially the poor to reach the facilities and establish community support group with local leadership and an executive committee where 50 percent of the membership is allocated to women. The CmSS are village level committees that comprise local villagers, mostly poor families, local community leaders including UP chairman and members and influential leaders.

The roles and responsibilities of the committee include identification of pregnant mothers, registration of pregnant mothers, ensuring and follow up 4 ANC visits by all pregnant women, referring, extending financial support to the poor for treatment of complications, and encouraging savings by pregnant women during pregnancy for aiding financial support at the time of delivery, Building awareness of pregnant women, making aware the family members of the pregnant women where to deliver to support families to have essential services for newborn care, to arrange transportation services for complicated cases, updating the list of pregnant women, raising health and family planning awareness and also awareness related to other social vice such as dowry, violence against women and prevention of early marriage.

One interesting initiatives by the community is the public private partnership approach. In some cases District hospital or MCWC may be too away to transport women for emergency service, the CmSS has signed MOU with a few nearby local private providers of EOC services at almost half the price of what they would claim from other patients.

One key difference between CC based community support group and CmSS is that in CmSS there is no inclusion of field level health and FP staff in the committees. Committee members are local villagers and they themselves take the decision, convene and hold the meeting, mobilize resources, make their own plan and follow up their own activities. In case of some very successful CmSS it was revealed that extensive initiatives of a local community leader especially the UP chairman and support extended to him by the local community was unique.

A situation analysis conducted in 2011 on CmSS analysed the project monitoring data and evidenced that there was an increase in the trend of met needs of emergency obstetric care (EmOC) in the intervention areas. The same study rated 53% of the 151 CmSS under category A. These are likely to sustain their activities without project support. Compared to non-CmSS area CmSS area showed higher rates of ANC/PNC usage, practice of measuring BP, knowledge of five danger signs during pregnancy, and proportion of CSBA assisted and institutional delivery.

Visit to successful CmSS area health facilities showed much higher attendance of patient in both CC and UHFWC than the national average which is evidence of impact on community awareness. A UHFWC reported an average of 250 clients per day while a nearby CC reported 150 services recipients per day due to the availability of service providers and medicine. The monitoring and supervision of local committees as well as UP chairman are very remarkable. The female committee members visit home to home to motivate the husbands and mothers-in-law regarding the care and importance of ANC during pregnancy.

The Narsingdi model has been brought to its present stature with continuous and consistent support of CARE and JICA staff. It will be a matter and observation of future studies to see what happens when JICA and CARE supports are withdrawn. However, it is important to note that recognizing the success of the CmSS approach, the government of Bangladesh has decided to introduce the CmSS approach in revitalizing the community clinic where the CSG would be an integral part of the community support system.

Lessons learnt from Narsingdi Model:

- Creation of Community Support Group seem to be a good option for generating community support for emergency transportation of patients
- This model is purely a grassroots level initiative, if proper grooming for a few years with necessary technical and other support is provided to the local community, this model is likely to survive.
- Resource mobilization at the grassroots level is possible if community people can be properly oriented.
- Proper identification of local leadership will be necessary to keep the momentum of the initiative
-

4.3 The Chokoria Model (ICDDR,B)

ICDDR, B started implementing the Chokoria Community Health Project (self-help for Health) in 1996. The first few years (1996-2002) were spent on health awareness raising and building rapport with the community as the local community was found extremely conservative and movement of women was not only restricted but also under veil. From 2002 onward, ICDDR,B started extending technical collaboration to the members of a local youth club in Kayiar Beel Union where 30 paramedics were trained in 3 years, 13 midwives from the local community were also trained. A local donor living abroad donated a piece of land with constructed building to the local youth club led by Mr. Zillur Rahman, the secretary of the youth club. After receiving the land and building Mr. Rahman approached ICDDR,B for technical assistance.

Amader Saystha (Our Health-OH) – Initiative of ICDDRB, Chokoria project
Amader Saystha (Our health-OU) is a project managed by ICDDRB where outdoor treatment including hospitalization cost is borne by the villagers. This is a pre-paid health project.

Membership Rule:

- Anybody desiring to become a member can take help from Grameen Shaystha Paramarsha Kendra or Village Heath Post (VHP) or village representative
- Only one person from one family can become a member
- Tk-1200/- has to be paid at a time for one membership.

- One card will be given to one member that will give coverage up to six members of a family
- The Card has to be renewed after every one year

Facilities against the card:

- Treatment from trained Medical assistant and Doctor at VHP.
- If needed treatment is offered by taking online advice from specialist.
- A discount of 50% on all medicine as against the inscribed company retail price.
- Arrange hospitalization if necessary.
- All diagnostic test/examination done as necessary for treatment.
- Members will receive treatment cost Tk-54000/-yearly for a family with maximum Tk. 9000/-for each as coverage

In addition as a member of Amader Shaystha , one can take another card for **ANC & PNC with caesarian operation coverage** with payment of Tk-2500/- at a time (for one pregnant woman & one pregnancy) from the same family.

ANC timing:

1st service- 1-3 month's 2nd service- 4-6 month's 3rd service- 7-8 month's 4th service- 9th months

PNC timing:

1st service- Within 24 hours after delivery, 2nd service- Within 25-72 hours after delivery, 3rd service- 73 hours to 7 days

Normal delivery:

From the time delivery pain starts, availability and service of trained Midwife is ensured

Caesarian delivery:

After delivery pain starts & referred by Midwife, during pregnancy service, Referred by Doctor

Coverage- under ICDDRB technical cooperation VHP centers at Chokoria Upazilla are as follows

- Kaiarbil Union
- Kakara Union
- Paharchada Union
- B M Char Union

Lessons learnt from Chokoria Model:

- The amount of Tk.1200 is not poor-friendly as poor people cannot afford to pay this amount in advance
- The module is not prepared for free treatment for poor patients. Rather the target is to sell 4000 cards to make the project sustainable. So far 250 cards have been sold.
- We can learn the management aspect of the project like- (a) Those who work will have to have high level of motivation (b) Creation of a data base to adopt a Health & demographic surveillance system allows understanding and monitoring client level socio-economic profile and health condition.
- To minimize the cost & time IT support system has to be established for quick recognition of patient with history.

- Selection of committee members from local youths belonging to the age range of 19 to 23 and who should represent various clusters (all areas proportionally) has been very fruitful. Provision for training on the project objective, mission, and strategies to the local youths has reinforced their commitment.
- Health volunteers from amongst the students and local young unemployed people (girls & boys), selected to work temporally for a particular task. It had two fold impact- one was that as local persons these volunteers could motivate others, the other was that they got benefit of part time employment .Moreover they are likely to work as ambassador in future programs.
- Initiatives to collect local resources like- community financing projects and donation from the local elites, GOB, Upazila parishad and elected members, Zakat fund , philanthropic organization funds helped a lot for project viability and creating Emergency Fund for the poor.
- Contract partnership agreement with the GOB, private hospital, NGO, INGO for referral services.
- Health fair has to be arranged with local authorities with initiative for campaign, knowledge dissemination, and interaction with other professionals.
- Specialized doctors have to be available to see patients at least once a week that are 4 days a month in VHP. Local hospital will arrange to collect and list the patients.

4.4 The Local Level Planning (LLP) Programme

LLP was first introduced in 2000-2001 and was piloted in 39 upazilas under 5 districts during Health and Population Sector Program (HPSP) and implemented jointly by both the Directorates of Health and Family Planning. Following the evaluation of the LLP Pilot in 39 upazilas, it was "rolled-out '' country wide. Local Level Planning was one of the priority concerns of MoHFW under Health Nutrition and Population Sector Programme, HNPSP (2003-2011). In 2008, it was decided by the MOHFW to introduce LLP in 6 more districts and its 14 upazila hospitals.

The main theme of LLP is the planning from bottom level; here the community people are the key persons to locate the problems, identifying the solutions and the areas of interventions. Discussion with upazila level staff and officials in Debahata upazila of Satkhira district where LLP programme is being piloted revealed that LLP programme has lost its initial enthusiasm. According to some of the respondents in the upazila LLP was a nice initiative because the plan originated from the bottom level. There was also the scope of involving various local stakeholders in the process. The problems identified by the stakeholders and service providers could be solved locally. Proper utilization of resources could be ensured through this program. However, all were of the opinion that although LLP started with very good intention it has not been possible to sustain the momentum for various reasons such as doctors remaining very busy with other works, other meetings are held where issues are discussed and covered, and irregularity of holding the planning meeting and failure to implement decisions because of the lack of financial authority. However, LLP planning meetings are held in many upazilas and one main reason why all concerned attended the meeting was that Tk.400 remuneration was paid for attending the meetings. Nevertheless, because of the training imparted to the staff at upazilla and district level they got some expertise in preparing a plan and so LLP helped staff capacity building.

A study conducted by RTM International in 2009 on the "Evaluation of the Process and Impact of LLP showed that "the existence of LLP was only in the level of motivation, awareness raising and planning. The financial budget is still allocated as per central allocation system." The study interviewed selected district managers who complained that LLP oriented yearly budget was not allocated to them, and so they were not able to carry out LLP as planned. The upazila managers claimed that most of the post of doctors and other staff remained vacant for which it was not possible to carry out the target as per plan.

All the district and upazila managers interviewed during the evaluation of the LLP programme positively viewed that LLP was helpful to solve the local problem easily since it was planned locally, was a well coordinated program for solving local health issues and was capable of strengthening the community health services. However, 100 percent implementation of LLP was practically absent in all the districts. Because, the financial part of LLP was not yet implemented from the central authority for which achievement of target of LLP was not possible with a centrally controlled financial allocation. Some of the reasons cited for failure to achieve the target included unavailability of fund according to LLP, lack of manpower, infrastructure problem, and lack of proper supervision and monitoring. The evaluation study observed that monitoring system was almost absent and recommended necessary improvement in planning, execution, and monitoring and fund allocation. Discussion with central level officials found that due to budgetary constraint and lack of manpower it was not possible to provide monitoring effectively and perfectly and also the budget given in LLP was much higher than the central allocation.

Another reason for failure of the LLP was that there was no follow up meeting with the community later on. So, it ultimately turned out to be a routine work for the health and family planning program.

Lessons Learnt from LLP

- It is the general opinion that LLP was now confined in preparation of the plan only. No such programme will be effective unless local mangers have enough financial authority
- Currently financial allocation in health and family planning is not disbursed according to LLP recommendations. The allocation is disbursed according to central allocation rule.
- One barrier for effective implementation of LLP is the shortage of human resource in the upazila health complex and upazila health and family planning office.
- No good programme will be sustainable unless supervision and monitoring are strengthened and integrated within the system of the programme. There should be a system of accountability in any programme.

4.5 The LINK MODEL under Participatory Rural Development Program–II(PRDP-II)

A Link Model was developed by Bangladesh Rural Development Board (BRDB) & JICA for accelerating development activities through united effort and coordination which is an objective of PRDP-II. As of March 2012, the link program covered 64 districts, 85 Upazilla & 100 unions by forming 686 Gram Committee (GC-village committee) and 100 Union Coordination Committees(UCC) that benefited 959503 villagers. A Link Model is a network of linkages among various stakeholders involved in village development to facilitate communication and information among them for easy and transparent accomplishment of various development activities at the village level. The Inherent objectives of Link Model are:

- To ensure local governance through accelerating organizational linkages, cooperation and coordination
- Initiating and strengthening internal and external linkages between the service providers and service recipients

The Link Model follows a strategy to make vertical link in between upazila, union and village while horizontal link between UP member, GC representatives, nation building departments (NBD), and public representatives in order to ensure information flow by establishing coordination and linkages.

The establishment of link model has three-fold strategies. They are Gram Committee Meeting (GCM), Union Coordination Committee Meeting (UCCM) and the link role of Union Development Officer (UDO). UCCM is the forum in Union to exchange views with UP, GOB/NGO workers for coordinating Village development while Gram Committee Meeting (GCM) is a forum for villagers to exchange views with GOB/ NGO staff officers in the village level. The UDO makes the entire above link through GCM-UCCM and manages meetings. UCCM-GCM is the platform for rural development where all villagers hold discussion face to face on development works which is open to all. It is believed that open discussion & exchange of views among service providers and beneficiaries through UCCM & GCM have a very good impact on development works. It helps to develop cordial relation as well as creates scope to know the role & works of each other.

Major Link model components:

Gram Committee (GC): It is constituted by the villagers with the consensus of all villagers. This is a forum to discuss all problems and find out solution in presence of all (GO-NGO & villagers). It contributes to integrated village development. One representative from GC is the member of UCC.

General Meeting & Gram Committee Meeting (GCM): When one person from each family attends a meeting which is known as General Meeting (GM). It is mandatory to call a GM for forming a GC. Otherwise by taking resolution in GCM – GM may be called.

System of formation of GC: At least 60% presence (considering at least 1 representative from each Family) is needed to form a GC. The age of a GC member must be over 18 years. The size of GC should be between 15-30 members depending on the number of households who are selected for the duration of 3 years where one female member is included from each Para. Portfolio positions (Chair, Vice-Chair, Secretary and Assistant Secretary) are selected by proposing and seconding the proposal from among the members.

Functions of GC: GC- Every month is held at least once in month where the quorum is fulfilled if 50 percent of the members remain present. Resolution of the meeting is written by Secretary of the committee. It is an open meeting; anybody outside the committee member may join without hesitation. Union Parishad members have the opportunity to know the demand of the villagers and can make any suggestions or recommendations. The specialty of the meeting is that it obeys the taboo of village and goes with local cultural norms of discussion as in any normal village meetings.

Activities of GC: The decisions of the Union Coordination Committee Meetings (UCCM) are discussed to identify the problems on priority basis and plan its solution. Service providers

(NBDs) give recommendation and decisions are taken after discussion, and evaluation of the proposed plan for village development.

The decisions taken in GC are produced in UCCM and on the progress of GO-NGO related activities and are considered for onward action. Side by side, UCC-GC meeting decisions are made available to all through personnel or Para meeting. All out cooperation is given to GO-NGO program in the light of UCC-GC decisions.

Monthly Union Coordination committee (UCC): Members of the UCC are members of the Union Parishad, all Union level officer/staff of GO-NGO & representative of GC as per GOB circular. Agenda of meeting is to review progress of GO-NGO activities

Highlights of UCCM- Meetings are held once a month, presence of 50 percent members of committee fulfills the quorum and postponed meetings are to be held within 7 days. Resolutions are written and all concerned are informed, all problems are solved locally and in case of failure it is referred to upazila authority.

General Agenda of committee:

1. To evaluate the progress of the concerned union level department/ NGO
2. To optimum use of resource collected from various sources.
3. To integrate and communicate with all nation building departments & link local people with development works.
4. To integrate & link UCCM with GO-NGO organization of the Upazila.
5. To evaluate Local Level Development planning
6. To organize, motivate villagers socially for creating congenial environment for development activities.
7. To co-opt members of UCC from local NGO nominated by UNO
8. Any other related business

Union Development Officer (UDO): To activate & run effectively UCCM & GCM –UDO works as the lead person who is also the Member Secretary of UCC and is responsible for following activities (1 UDO for 1 Union):

- communicate with all concerned, integrate the development activities, and organize villagers, and is the focal point behind planning & implementation
- Make link with GO-NGO flow of services for overall rural development as per demand of the local people.
- Responsible for linkage with resources & services of GO-NGO to villagers and collect/ preserve necessary information
- Responsible for UCCM meeting organization, follow-up, resolution writing and distribution.
- Help run GCM effectively and as per plan

Characteristics of Link model:-

Exchange of views/information: It is possible to disseminate the organization's activities and development plan to other organization through exchange of information. As a result the concerned organizations have the opportunity to know each others works, location, and problems making the activities systematic, accountable & easy.

Participation: If all the general people (women specially) of the village participate in development with money & labor then the element of ownership is formulated in the process. It will be effective only when participation in planning, implementation & evaluation of all is ensured. Female participation in discussions of GCM will expedite the Development of village especially in health & education

Lower to upward planning: Villagers know their problem very well so it is better to make plan by discussing the villagers where GOB-NGO of respective departments give technical supports. There should be a system to solve the problem upward if failed locally.

Implementation of Link Model may be time consuming. The secret of success of this model is the creation of working environment which takes a long time keeping pace in conformity with the local culture and socio-economic condition. This program has become popular as it has created resource from the Union parishad fund with collection of various taxes. People know what development initiatives are taken in their union while all nation building departments discuss their development efforts. UDO has an office at the Union Parishad and all information is there which facilitate all departments to know the latest information for their work. Above all, priority infrastructural work contributes to the overall development of the village as well as job creation. It has been learnt that GOB is thinking to implement the program throughout Bangladesh in future.

Lessons Learnt from Link Model:

1. One Moderator with assistants & office is needed to achieve the program objective.
2. Initially 5 years time is needed for back up financial support while side by side sustainable plan has to be implemented.
3. Local resource collection initiative is a must for sustainable running of the project in future.
4. The Program should to have the provision of adapting and adjusting changes learnt in the process
5. Massive training has to be arranged for all concerned.

Section 5: Recommendations for strengthening the role of local committees for implementation of SSK

5.1 The role the community level committees could play

In response to the question whether this committee could play any role to get the poor involved in SSK, the common consensus was that they would be able to help identify the poor, inspect and monitor the present health services regularly, and inspire them for taking treatment/advice from the doctors at UHC and FWC, Keep continuous awareness of mistreatment that result even to death, etc. In Tungipara the response was a further step ahead claiming that they would be able to organize health group consisting of (trained) health group volunteers, appoint volunteers from among young educated persons interested to work part time and create a fund collected from health cards that can be used to pay volunteers. They could also take initiative for local level motivational campaign.

In Debhata, the committees were in favour of initiating intensive effort for better motivation of the poor. For this the committee members could be involved in arranging meeting/workshop in their own areas for identifying the community problem and need. With the help of local authority, the committee could arrange meeting with the local community for mobilization and utilization of local resources.

Regarding the role of the committee in implementing the SSK, they common idea was to plan locally by identifying the problems through discussion with the general patients, to monitor program if they are provided proper training, to create base of local health issues related data and to discuss at all levels regarding the improvement of health through accountability and implement the recommendations phase by phase.

For budgeting in SSK, following the government guidelines (LLP) and analyzing the activities of recent years the committee could prepare a budget locally. This would require the advice and guidance of existing officials, committee members, retired related persons and elected members of the locality for reflecting their views in the budget. They could also mobilize resources locally from well-to-do people and utilize the fund for improving the health services, purchase of medicine and locally available equipment. They could also assist in mobilizing resources from local government, upazila parishad, local elite and philanthropists. .

The committee could also play monitoring role in the SSK by reviewing the progress of work, ensuring patients rights, facilities, and priorities –indicators could be determined to ascertain the monitoring strategies. Through regular analysis of activities of all staff, the committee members could find out the drawbacks and strengths and utilize these analyses for improvement of the SSK programme. There would be need for dividing specific responsibility of each member of the committee which is not the current practice anywhere. The committee has to be responsible to access the progress regularly and discuss the findings in the committee meetings to resolve any issues that are raised on the spot. Regular and spontaneous inspection, audit and immediate actions and follow up to solve any problem would be important roles.

5.1.1 Recommendations for strengthening the role of the community level committees

- The committee could be involved in the participatory process (PRA) of identifying the poor and the local level problems

- The community based committee could be utilized at the formative stage to identify the local level problems, raise awareness of the beneficiaries and people in general through local level motivational campaign, courtyard meetings (Uthan Boithok) and through arranging film show/health fair etc. to attract the local poor to have the SSK services.
- In the process of implementation of SSK committee members and concerned staff of CC could be utilized for urgent and effective communication
- Payment of honorarium should be introduced for attending committee meetings and that will also ensure regular holding of the meetings.
- Every member of these committees should be given proper training and orientation to mould them into understanding the process, planning and implementation of the SSK project.
- The committee could be motivated and encouraged to mobilize resources locally through all possible initiative including donation from local elites, UP tax fund and other possible sources.
- They committee can bridge the relationship between the client and provider and ensure better provider behavior and provider accountability through regular contact and coordination meetings with providers.

5.2 The role the Union level committees could play

As the current union level committees are Union Family Planning Committees and FP functions implemented through the Directorate General of Family Planning, it is difficult to anticipate any role that this committee could play in SSK. The reason for this anticipation lies in the fact that SSK will provide inpatient hospital services and will therefore be implemented through Directorate General of Heath Services (DGHS) staff. Since there is no representation of DGHS staff in the union level committee, this committee may not be effective in the implementation of SSK. If Union level committees are to involved, it should comprise union level field personnel from DGHS . There Moreover, there may not be need for any union level committee as there would be community support group and community group which if effectively utilized would serve the purpose of serving the community interest. Since UP chairman and members are important local government representatives they can utilize the FP staff for information dissemination about SSK. The case study of model CC "Dimadanga Model Community Clinic" in Tungipara of Gopalgonj district has been annexed in **Annex-A.**

5.2.1 Recommendations for strengthening the role of the union level committees

- Union Level committees should be formed comprising both H&FP field personnel
- Union Family Planning Committee could include SSK in their discussion agenda and motivate and network with community people if the government so desires.
- As the grassroots level FP workers come regularly in contact with all categories of community people, they can play a vital role to disseminate the objective of SSK and enhance the activities of SSK.
- UP chairmen and members who are members of FP committees should be involved from the beginning and oriented properly and they are likely to provide any service for SSK for the sake of their own political interest.

5.3 The role the Upazila level committees could play

Since this an advisory committee and is too big in size their involvement in SSK should be cautiously designed. It would be probably meaningful if a subcommittee (as per government provision) could be formed with relevant members who could be involved from the very beginning in the process of implementation of SSK. However, since this committee is an upazila hospital management committee, all types of facility improvement issues could be discussed and resolved through this committee. There should be a focal point for the programme in each upazila designated as "Upazila SSK Coordinator" as they follow in case of Demand Side Financing (DSF) pilot designating Upazila DSF Coordinator. Otherwise implementation may not be so easy as the UHFPO remains very busy with routine administrative and service delivery work.

5.3.1 Recommendations for strengthening the role of the Upazila level committees

- Upazila health complex controls the health facilities located at union and community level through UHFPO and UFPO. In addition staff coordination meetings held regularly to discuss the problems and find out the solutions for smooth operation of the upazila health issues. So opportunity is there to spread SSK ideas through the agenda in the coordination meeting. The health staff could play vital role to motivate the stakeholders/beneficiaries to utilize the benefits from SSK.
- This UHMC can make a list of the service holders, affluent businessmen, lawyers, doctors, businessmen, and other professionals who hail from the same upazila but live outside the upazila for regular donation for the poor as they do in Chowgacha Upazila in Jessore district. The committee should be utilized for local resource mobilization at the upazila level.
- Provision of fund to pay honorarium and for refreshment for attending the meeting should be created to attract regular attendance and ensure more participation.
- Orientation should be provided to all committee members to build their capacity for the successful implementation of the process, objective and modality of SSK and also the monitoring role of the community members for ensuring the quality of service.
- If MP as chairman of UHMC regularly attends and chairs the meeting many other will feel encouraged to attend.
- UHMC meeting should be held quarterly. It creates opportunity to follow-up the meeting as well as chance to regularize it. The MP is a busy person but he can give time if contacted ahead of time.
- If someone who resides at the upazila permanently and who can be regularly and easily contacted chairs the committee probably the committee functions would be more effective. The MP can nominate someone of his her choice.
- If the committees extend full cooperation to the facility staff and exchange ideas and listen to their problems and constraints and encourage them for their good performance, it will improve service quality, and increase facility utilization. So, there should be a provision for experience sharing by the staff with the committee members.
- There should be a system of giving award to the best performing committees at all levels on the basis of certain criteria so that there is sense of competition for better performance across all levels.

5.4 Other recommendations for SSK

For successful and smooth implementation of SSK, the following recommendations may also be useful for the implementation:

- Funds have to be released locally at the beginning of the year in the reimbursement process and committee has to be made liable for any misappropriation or deviation of financing rules.
- The committee should adapt the LLP model for budgeting and annual plan so that the plan could be executed following the planned budget
- Local resources procurement plan has to be made annually to identify the sources of local resource through discussion in the Annual General meeting (AGM)
- Budget, Annual Plan and monitoring policy have to be placed in the AGM for discussion and recommendation and finalization of the above in the light of the decision.
- The MP has the access to higher level policy makers and planners and as such could be utilized to expedite and execute the committee decisions with necessary direction and administrative support.
- It is possible to solve many problems locally if initiatives are taken so that this role has to be played in combination with the joint understanding of local level staff and community people. Local staffs as such have to be given proper motivation and orientation about SSK goal and objectives.
- Facility managers should have funds for handling emergencies like purchase of life saving drugs, emergency repair of facility equipment, machineries and vehicle and any expenses needed to keep the OT functional.
- Reimbursement process for program related expenses should be made smooth and easier and joint responsibility may be assigned to the facility manager and respective community leader.
- A system like BIRDEM can be introduced to keep a medicine fund with early to the local Manager to buy medicine from local shop for supply to poor patients free of cost in case of emergency care.
- SSK should provide prior guideline before giving responsibility to any local committee. Otherwise there will be lot of chaos and confusion regarding the selection of beneficiaries, handling of funds etc. Reimbursement procedure should be made simple and transparent

.

Section 6: Conclusions and Recommendations

The study has evidenced that local level committees that have been created by the local people have a better chance of survival. The only committee that has some evidence of functioning is the CC based community support group, as its members are mostly people of the locality discussing and solving their own problem. All local level committees should be formed at the initiative of the local people so that they take the ownership and are ready to redress their own problems. JICA supported Narsingdi model is purely a community based local committee model and can be considered and piloted for replication. Although Chowgacha appears to be the best service delivery point, the replication attempt of this model has not been successful. The dynamics of Chowgacha is very complex and success depends mostly on the dedication of group of service providers who could establish unparalleled good governance at the facility. It is difficult to combine such a group in one place in the public service delivery system. The ICCDDR,B model may not be very cost effective and also not poor friendly and it took longer time for building rapport and community linkages.

It is not always possible for the government to provide resources and the burden on the government is increasing every year. In this backdrop community should be encouraged to mobilize resources. That is very much possible as we learn from both Chowgacha as well as Narsingdi project. For efficient implementation of SSK our recommendation would be to borrow from Chowgacha some of the facility improvement aspects while from Narsigdi most of the community aspect could be replicated. The government has already taken decision to integrate CSG system into the CC strengthening purpose.

The study has reviewed the functions and limitations of LLP. It could be a very good model if financial allocation was given as per local plan. But that did not happen and the dynamics of LLP to fuction plan, and budget locally has died down. The study has cited the Link Model of BRDB, the pilot can coordinate with BRDB to explore the possibility of integrating the health aspect in the link model. So, SSK should try all the three separate models for community involvement while facility level preparation should be standardized across all the pilot areas.

The overall goal should be to bring more poor under service coverage and representation of the poor at all levels of the local committees should not be overlooked. So, some of the key general recommendations for SSK are as follows:

- Funds have to be released locally at the beginning of the year for smooth implementation of SSK.
- Facility managers should have fund for handling emergencies like purchase of life saving drugs, emergency repair of facility equipment, machineries and vehicle and any expenses needed to keep the OT functional.
- Reimbursement process for program related expenses should be made smooth and easier and joint responsibility may be assigned to the facility manager and respective community leader.
- A system like BIRDEM can be introduced to keep a medicine fund with the local Manager to buy medicine from local shop for supply to poor patients free of cost in case of emergency care.

Annex-A: Case Study of Gimadanga Community Group

Gimadanga a CC committee with a difference (Gimadanga Model Community Clinic).

It is a CC committee named Gimadanga Community Group which is named after the village where the CC is located in Tungipara upazila of Gopalgonj district. In April 26, 2000 Hon'ble Prime Minister inaugurated this CC. The beautifully built infrastructure of this CC is widely known to all. Members of this committee conduct their activities at their own initiative. There was no interference in their activities during the change of government. It is run by the effort of the local community.

Background reasons for the committee's effective activities are-

- The President completes his task on his own initiative. During the construction of the clinic he helped to bring mud, brick etc.
- To spot-light the event he arranged a dialogue with the local elites.
- All are local inhabitants so entire activities are done with the coordination of all.
- In emergency cases the Health Assistant (HA) takes the patient at his own to Upazila Health Complex.
- Hard paper card is given to each patient (irrespective of socio-economic status and mostly poor pregnant mothers and children) who comes to CC for service and 2 Taka subscription is taken against each card. With the help of this card patients can make proper subsequent follow-up visits. Date of next visit is indicated in this card. The fund accumulated from the sale of this card is used to buy medicine for the poor so that no service recipient one returns without medicine.
- All the specimen medicine received from different pharmaceutical companies is also given to the patient free of cost.
- Blood donation program is conducted by the local community.
- Special treatment is provided to the patient (approximately 2 days in a week) with the help of external doctor.
- Medicine and service is also provided in emergency situations by committee members by donating specific amount of money.
- President make follow-up for ensuring regular doctor attendance.
- If anyone ignore his duties then he need to accountable for that.
- There is a fund for refreshment of committee members but it is self contributory and not any fixed fund.