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

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BRAC	Bangladesh Rural Advancement Committee
BRDB	Bangladesh Rural Development Board
CC	Community Clinic
CG	Community Group
CS	Civil Surgeon
DC	Deputy Commissioner
EPI	Expanded Programme on Immunization
ESP	Essential Services Package
FGD	Focus-group Discussion
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HA	Health Assistant
HPSP	Health and Population Sector Programme
MA	Medical Assistant
MCH	Maternal and Child Health
NGO	Non-government Organization
NID	National Immunization Day
NK	Nijera Kori
NSC	National Stakeholder Committee
RD	Rural Dispensary
RTI	Reproductive Tract Infection
SACMO	Sub-Assistant Medical Officer
THC	Thana Health Complex
TH&FPO	Thana Health and Family Planning Officer
TOR	Terms of Reference
TSC	Thana Stakeholder Committee
UH&FWC	Union Health and Family Welfare Centre
USC	Union Stakeholder Committee
VHSS	Voluntary Health Services Society

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Executive Summary

Introduction: Participation of stakeholders in healthcare, a major policy theme and a fundamental principle of the Alma-Ata Declaration (1978), is still considered an essential part of health development. Two international conferences, held in the mid-1990s, emphasized on the rights of users of health services to high-quality, affordable, and accessible health services. Users of health services, especially women and the civil society, need to participate in planning, monitoring, and evaluating health services to address their needs and rights, and to hold the State accountable to their agreements.

The roles of stakeholders, i.e. users, civil society, and non-government organizations (NGOs), in systematic monitoring of health sector activities are critical for improved governance. Under the rubric of community participation aiming at building a partnership between government and people, numerous projects attempted to increase a wider role of the community in their health development in many parts of the world. The use of community-donated space for Expanded Programme on Immunization (EPI) camps and satellite clinics for providing immunizations and reproductive health services to women and children have shown the way how the community can contribute to their health development. To optimize the use of available resources and to ensure effective coordination in programme planning and implementation, various committees were formed at different levels of the health system in the past in Bangladesh. Information on different committees formed at health facilities, e.g. health and development committee, family planning committees, is scanty, but reveals that there were too many committees. Most committees remained non-functional due to lack of vision, workplan, and action.

The Health and Population Sector Programme (HPSP) of the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh, developed a mechanism for participation of stakeholders at both local and national levels in the Project Implementation Plan (PIP). To facilitate this process at the national level, the MOHFW established a National Stakeholder Committee (NSC) consisting of representatives from different stakeholder groups. The NSC prepared a one-year workplan, and formed 9 Thana[1] and 16 Union Primary Stakeholder Committees in late 1999 to facilitate the incorporation of the community's voice into health programme to establish their right for transparency and to build a foundation for programme accountability. The membership of the committees comprised users of the Essential Services Package (ESP), especially the poor and female members of the civil society for advocacy on health issues.

Objective: The study assessed the implementation processes of Stakeholder Committees, and effects of the committees, especially participation of ESP users in incorporation of community's voice into HPSP to establish transparency and accountability in the programme.

Methodology: Four of 9 thana and six of 16 union committees from three divisions of Bangladesh were purposively selected. Data were collected through in-depth interviews of committee members, thana managers, and service providers of MOHFW, focus-group discussions (FGDs), exit interviews of ESP users, and review of records. Four teams, each with four trained researchers including one female, collected data in October 2000.

[1] Thana has been renamed as upazila, and designations of MOHFW officials and title of facilities have changed accordingly.

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

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

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

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

About 60% of both male and female members were aware of the HPSP, and half of them could explain the NID. The female members were knowledgeable about the EPI sites as a place for vaccination of children aged less than 5 years and tetanus toxoid (TT) for pregnant women and Satellite Clinics (SCs) as a place for serving pregnant mothers. The knowledge about Union Health and Family Welfare Centres (UH&FWCs) was almost equal between the male and the female members. Similarly, the knowledge about Thana Health Complexes (THCs) was higher among the male members compared to the female members. The female members had low knowledge about Community Clinics (CCs) compared to the male members. The knowledge of female members about reproductive tract infections (RTIs) was higher compared to the male members. The female members could provide some explanation about RTIs. Seventy-eight percent of the male members and 23% of the female members viewed sexually transmitted diseases (STDs) as a bad disease. The male members than the female members had more knowledge about acquired immune deficiency syndrome (AIDS) as a dreadful disease for which there is no cure and HIV as a germ causing AIDS.

The members of thana committees were more literate than the union committee members. Sixty percent of the thana committee members had higher secondary grade education, and it was 22% among the union committee members. Fourteen percent of the union committee members had no formal education. The proportion of owners of cultivable land was higher among the union committee members than among the thana committee members. Although there was an equal representation from the poor socioeconomic group and females in both the committees, they were selected mainly from working areas of facilitating NGOs (four NGOs facilitated Stakeholder Committee activities in intervention areas).

Although there was no major opposition from the service providers, the thana-level managers of MOHFW were reluctant to cooperate with the committees. Some managers of MOHFW felt to be disgraceful in monitoring the activities of health centres by the committees. The Stakeholder Committees did not follow any standard procedures

in implementing their activities. Absence of monitoring by the NSC and lack of necessary funds affected implementation of committee activities.

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

Recommendations: One of the main objectives to form Stakeholder Committees was to improve the delivery of ESP at thana and union levels through systematic monitoring by the community groups. But systematic monitoring of the activities in the national programme is yet to be well-established. The Stakeholder Committee members were also not certain about the type of monitoring role they are supposed to play. The thana managers and service providers of MOHFW were not familiar with the activities carried out by the Stakeholder Committees and what decisions were taken in the committee meetings. Therefore, institutionalization of the monitoring system by a community group is unusual for the thana managers and service providers of MOHFW, and should be proceeded with caution. Despite divided opinion, any decision to include the service providers in Stakeholder Committees merits action research.

Wider participation of the community in both thana and union Stakeholder Committees needs to be considered in future. To ensure implementation of the committee activities, a manual should to be developed. Necessary funds should be made available to meet related expenses for organizing meetings of committees and carrying out their activities.

The role of NGOs in facilitating the activities of Stakeholder Committee needs to be well-defined. It is not clear whether this role can be sustained. The NGOs should plan to delegate the facilitating role to the committee members. Effects of such delegation should be evaluated.

Close linkage with the local government institutions for getting necessary support will contribute to strengthening the committee activities. For promoting the community's voice for improved health outcomes, the stakeholder committees should maintain a close link with the local women organizations to propagate a client Bill of Rights, so that the users can demand services from the health centres.

Regular feedback from the NSC will encourage the committees to carry out their activities effectively. The performance of Stakeholder Committees was comparatively better than that of the past committees. Therefore, further action research will help find out how the previous committees could be merged or linked with the Stakeholder Committees.

Absence of area-specific baseline information and information from comparison areas prevented to make any methodologically-sound comparison between before and after the committees were formed and with comparison areas of health and the community-related indicators. Therefore, further research with baseline information and with information from comparison (non intervention) areas needs to be carried out.

Policy implications: The MOHFW needs to develop a mechanism, so that the local-level providers can support the committee activities. According to the plan of HPSP, about 13,500 community groups (CGs) will be formed to support the implementation and monitoring of CCs. The MOHFW has to develop a mechanism to merge or establish a linkage between CGs and Stakeholder Committees.

Conclusions: Partnership with the civil society being a new concept to many needs to be mentored. Although the committee members are passive recipients of health services, they spend a considerable time for committee activities. The potential of involving the poor, particularly females, in the committees as a new dimension in incorporating community's voice into the HPSP to establish their rights is worth testing.

Background

Participation of stakeholders in healthcare, a major policy theme and a fundamental principle of the Alma-Ata Declaration of 1978, is still considered an essential part of health development. Participation of stakeholders in any programme is not a simple matter [1,2]. The Alma-Ata Declaration stressed that the people have a right and duty to participate individually and collectively in planning and implementing their healthcare programmes [3]. Two international conferences, held in Cairo and Beijing, emphasized on the need of users of health services, especially women and the civil society, to participate in planning, monitoring, and evaluating health services to reorient the services to address their needs and rights, and to hold the State accountable to their agreements [4]. To bring about changes in the client-centred policies and services, input and participation of clients at all stages of planning, designing, implementation, and evaluation are essential. This approach ensures that policies and programmes are responsive to local-level needs. It also empowers individuals, particularly women, as owners and agents of change in their own sexual and reproductive health. By extension, involvement of the civil society, made-up women's groups, non-government organization (NGOs), religious and youth associations, and other organized constituencies can ensure that the voice of those most in need is heard at all levels of the health and social systems. Participation of the civil society can indeed ensure monitoring to the extent to which these systems are accountable to the people they serve [5].

Under the rubric of community participation or community involvement aiming at building a partnership between government and people, numerous projects attempted to increase a wider role of the community in their health development in many parts of the world.

Findings of the Community Action Planning Project in Karnatak, India, showed that trained community leaders could motivate couples to accept the small family norm and to use contraceptives [6]. One-third of the project villages became self-reliant in planning, implementing and financing community activities. The Comprehensive Rural Health Project (CRHP), Jamkhed, India, has developed a successful model of empowering communities to take health into their own hands, especially through leadership of village health workers [7]. Experience in Indonesia suggests that community participation is possible in all stages of a development programme, and their increased participation can improve the quality of activities and contribute significantly to human development.

Health and population-planning activities and overall development having an impact on the community life, and without their participation, no significant improvement can be made in these areas [3]. Although not adequately documented, the use of community-donated space for satellite clinics for providing immunizations to children and mothers and other reproductive health services has shown the way how the community can contribute to their health development in Bangladesh. The village healthcare providers nominated by the community and trained by the government health authorities have been providing services from the village health posts with community resources [6].

To develop local plans for comprehensive health and family-planning services, the Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh (GoB), introduced Thana Maternal-Child Health (MCH) Coordination Committee, Thana Health Committee, and Union Family Planning Coordination Committee in the mid-1980s. Most of these committees were constituted with the Member of Parliament (MP), Chairmen of Thana and Union Parishads, and Thana Managers of MOHFW. These committees had to operate following the guidelines of MOHFW. The committees were supposed to meet every month to plan and review their performances and to set achievable goals and realistic targets. In reality, the MOHFW guidelines have not been implemented. Meetings of the committees primarily focused on the decisions of MOHFW to ensure effective coordination in programme planning and implementation to optimize the use of available resources. The available documentation on the roles and functions of these committees does not exhibit any conclusive evidence [8].

The MOHFW considers the participation of stakeholders and users of health services in all phases of project cycle, i.e. planning, implementation, monitoring, and evaluation, a vital element for achieving the goal of the Health and Population Sector Programme (HPSP) of Bangladesh. It has been emphasized in the HPSP documents that the participation of stakeholders in the HPSP is critical with regard to client focus, quality of care, social and gender equity, and decentralization. The MOHFW initiated the process of involving stakeholders in the preparation phase of the HPSP to build a partnership between the government and the people [9]. As part of the process, a National Stakeholder Committee (NSC) was formed in April 1999 with Joint Chief (Planning) of MOHFW as its chairman. Its memberships included GoB officials and representatives from different stakeholder groups (Appendix 1). Under the guidance of NSC, 9 Thana Stakeholder Committees (TSCs) and 16 Union Stakeholder Committees (USCs) were formed during September–October 1999. Four NGOs, such as Voluntary Health Services Society (VHSS), Bangladesh Mahila Parishad (BMP), Nijera Kori (NK), and Bangladesh Rural Advancement Committee (BRAC), were given the task of facilitating the preparatory activities and subsequent implementation of committee activities in their respective working areas of 9 thanas [10]. Activities of these NGOs vary considerably in their areas of concentration and mode of operation.

With support from these NGOs, a one-day workshop was organized in each of the 9 thanas prior to the formation of Stakeholder Committees. The district and thana-level officials of MOHFW, teachers, journalists, community leaders, users of essential service package (ESP), and religious leaders attended the workshops. Techniques of focus-group discussion (FGD) were used in this workshop for forming TSCs and USCs. The committees (Appendix 2 and 3) comprised users of ESP, especially poor women, school teachers, lawyers, journalists, representatives of the local government, and NGOs. The stakeholders were grouped into three main categories:

- **Primary stakeholders (users):** The category included HPSP users, especially women, children, and the poor.
- **Secondary stakeholders (service providers):** The group included field workers and supervisors of MOHFW, NGO workers, union parishad chairmen and members, private practitioners, and depot-holders.
- **External stakeholders:** The category included local community leaders and members of the law-enforcement authority.

The committees were formed to:

a. Ensure participation of users of health services and other stakeholders in the implementation and monitoring of the HPSP.
b. Broaden the understanding of and support for the HPSP and to build consensus on its specific elements as they are being implemented, and
c. Facilitate transparency and to build a foundation for programme accountability to users

The facilitating NGOs organized a two-day orientation session on the HPSP and committee activities for TSC and USC members. The committee members developed their own terms of reference (TOR) and workplan in the workshop (Appendix 4).

The workplan included the following activities:

- Monitoring of activities of Thana Health Complexes (THCs) and Union Health and Family Welfare Centres (UH&FWCs)
- Providing assistance on National Immunization Days (NIDs)
- Organizing health awareness-raising meetings in villages and schools
- Organizing dialogues with the community
- Generating demand for quality health services
- Helping the poor and women accessing health services
- Holding monthly meetings with health service providers and officials
- Collecting health-related data
- Informing the NSC about their activities and concerns

The MOHFW requested the Operations Research Project of ICDDR,B: Centre for Health and Population Research to carry out the study for assessing the effects of Stakeholder Committees on the community.

Objectives

This study was carried out to: (a) document the activities carried out by the Stakeholder Committees after their formation and perceptions of the committee members, users of ESP services, and thana managers and service providers of MOHFW, (b) assess the effects of Stakeholder Committees on the community, and (c) formulate recommendations for strengthening the committees. The specific objectives were to understand:

a. activities of Stakeholder Committees and extent of participation of members in committee activities
b. perceptions of committee members, users of ESP services, thana managers and service providers of MOHFW about the effects of Stakeholder Committees on activities of previous committees
c. knowledge of committee members on the HPSP and related issues
d. sociodemographic characteristics of committee members
e. strengths and weaknesses of stakeholder committees, and
f. formulate recommendations for strengthening activities of the Stakeholder Committees.

Methodology

Four thanas from Dhaka, Sylhet and Rajshahi divisions of Bangladesh were purposively selected. Special attention was given to select the thanas, so that one committee each of the facilitating NGOs can be represented. This was done due to varied nature of activities undertaken by each facilitating NGO. The selected thanas were:

Division	District	Thana	Facilitating NGO
Rajshahi	Bogra	Sariakandi	VHSS
Dhaka	Manikganj	Shibalaya	BMP
Dhaka	Tangail	Madhupur	NK
Sylhet	Sunamganj	Chhatak	BRAC

A team of four trained researchers collected data from each thana in October 2000. There was one experienced female researcher in each team. A questionnaire with open and close-ended questions, FGD guidelines, and other

necessary tools were used for collecting data. The following techniques were followed while collecting data:

a. In-depth interviews were conducted with chairmen, member-secretary and all other members of Stakeholder Committees and service providers. The service providers included Thana Health and Family Planning Officers (TH&FPOs), Medical Assistants (MAs)/Sub-Assistant Community Medical Officers (SACMOs), Family Welfare Visitors (FWVs), Health Assistants (HAs), and Family Welfare Assistants (FWAs). One HA and one FWA from each union of the selected thanas were randomly identified for interview.
b. Exit interviews were also conducted with users of ESP who visited to THCs and UH&FWCs.
c. FGDs were organized with currently-married men and women in the working areas of HAs and FWAs. Assistance of FWAs/HAs, originally selected for in-depth interviews, was sought to organize FGDs with users of ESP. In total, 6-8 users of ESP participated in each session. A two-member team (one moderator and one note-taker) conducted the FGDs. All sessions were tape-recorded with prior consent of participants.

The following box shows the category, number of respondents, and the methodology used for the study.

Methodology used/Category of respondents	No. of respondents
a. In-depth interview	
Stakeholder Committees	
All members, Thana	36
All members, Union	48
Service providers	
TH&FPO	4
MA/SACMO	6
FWV	6
HA	6
FWA	6
Previous committees	
Selected members, Thana	12
Selected members, Union	24
b. Exit interview of users of ESP	140
c. FGD with users of ESP services	12 sessions

Secondary data from minutes of committee meetings, registers, and published reports were collected and analyzed. Two experienced supervisors supervised the field activities for quality control of data.

Findings

Implementation Process of Stakeholder Committees

All committee members interviewed reported that the TOR developed for the committees was appropriate. A monthly workplan was prepared in regular meetings of the committees. The workplan included future activities with timeframe and information on persons assigned to carry out the activities. A review of minutes confirmed that all committees had their own workplan except in one union. About 63% of activities of workplans were implemented. Non-cooperation of thana and union-level health service providers and committee members, and absence of monitoring of committee activities by the NSC were commonly-cited reasons for not implementing the remaining activities of workplans. Absence of formal endorsement of committee activities by the higher authority of MOHFW was the main reason for non-cooperation of thana and union-level health service providers. One union committee member asked for conveyance bill or allowance for attending committee meetings. The committee members reported that, although the report on committee activities was sent to the Chairman of NSC every month after the formation of committees, they did not receive any feedback from anywhere about the activities carried out by the committees.

One of the main activities of Stakeholder Committees was to ensure that mandated meetings were regularly held at the thana and union levels. The status of planned committee meetings and attendance of committee members at meetings were encouraging (Table 1).

Table 1. Status of planned TSC and USC meetings held and attendance

Thana	Thana Committee			Union Committee		
	Planned	Held	Attendance %	Planned	Held	Attendance %
Sariakandi	6	5	89	12	8	98
Madhupur	6	6	87	24*	21	97
Chhatak	6	2	89	24*	15	100
Shibalaya	6	5	89	12	00	00

Source: *Meeting minutes* * Two unions

Table 1 shows that most scheduled committee meetings at both the levels were held, and about 90% of the members attended the meetings, except in one union. Meetings of the union committees at one thana were not held, because the members were not aware that they were supposed to hold the meetings. The Member-Secretary of one TSC, who is a representative of a facilitating NGO, informed that all scheduled meetings could not be organized, because (a) there was no instruction from facilitating NGO headquarters, and (b) there was not sufficient fund to meet up necessary expenses. The union committee members of one thana, where comparatively a less number of committee meetings were held, organized meetings with their own initiatives, and 8 awareness-raising meetings were organized in the community after the formation of the committee.

About 92% of the committee members reported that they had an equal scope to be involved in committee activities. The members could express their views freely in committee meetings, and opinions of others were well respected. In response to a question about reasons for high attendance of committee members in meetings and their high participation in committee activities, most members stated the following:

- Some members felt that the nature of committee activities was more of social work, which will ultimately enhance their social status.
- The facilitating NGOs insisted them to attend the meetings, and participate in the committees activities.
- Some of them were involved with other local committees for social work and to spend time.

In all the study thanas, a good record-keeping and reporting system of committee activities was observed. Resolutions of meetings were prepared, filed, and maintained, along with other reports (Table 2).

Table 2. Activities in TSC and USC meetings

Activities	Percentage of meetings	
	Thana	Union
Agenda prepared	83	91
Minutes available	83	91
Workplans reviewed	72	63
Local health problems discussed	92	97
Decisions initiated	78	91
Decisions implemented	70	69

***Source**: Meeting minutes*

Perceived Effects of Stakeholder Committees

Views of Stakeholder Committee members: The committee members reported that the committee consisted of people representing different professional groups. They came from the same community, and could identify the health problems of the community. It was easy for them to initiate necessary steps to solve the problems. Other than Stakeholder Committee, there are no other committees to discuss the local health problems and uphold the interest of the community. The Stakeholder Committees can play an important role to educate the community about health and family-planning issues. About 78% of the members reported that the committees were useful in the implementation and monitoring of delivery of ESP. Routine monitoring of activities of health facilities by the committees helped improve attitude and behaviour of service providers and satisfaction of clients, especially their services to the poor and women. Frequent dialogues with the service providers resulted in increased commitment to their responsibilities and their availability in the health facilities. In response to a question about the factors that contributed to well-functioning of the committees, the members mentioned the following:

- committees were balanced in terms of gender and socioeconomic groups, and had their own workplans
- committees could focus their activities on problems and needs of the poor and females, and could take initiative to solve the problems
- most committee meetings were held with 90% attendance, and followed formal procedures
- local health problems were identified in meetings, and steps were taken to solve the problems collectively
- Continuous dialogues between the committee members and the service providers about health services at the local health facilities minimized gaps between them.

Statements of four selected committee members, used here as case studies, provide an impression about the effects of committee activities*:*

- **A female committee member**

  There are some mothers-in-law in our area who prohibit their daughters-in-law to go out to receive Tetanus Toxid (TT) vaccines during pregnancy. There are also some elderly people who are in favour of adolescent marriage. I proposed in one of our committee meetings to organize a drama in our village to create awareness about

this issue in the community. The committee accepted my proposal. We organized a drama on health issues where many people were present.

- **A female user of ESP**

  I was suffering from blood dysentery and went to our hospital (UH&FWC) for treatment. The doctor (FWV) told me that there was no supply of medicine for my treatment. When I insisted her to give me medicines, she misbehaved with me and told me to get out from the hospital. I raised this issue in the next committee meeting, and proposed that the committee members should meet with doctor of our hospital. The committee accepted my proposal, met the doctor, and requested her to behave properly with the people of our area.

- **A poor male committee member**

  There were a number of grocery and stationery shops at the entry point of Rural Dispensary (RD) compound erected illegally by the powerful local elites. The privacy of waiting space for female patients was obstructed. In one committee meeting, I proposed to evict the shops from the compound. The committee accepted my proposal, and decided to remove the shops. The committee first met the shop owners, and requested to remove the shops. Some shop owners removed, but some did not. The committee submitted a memorandum to the Deputy Commissioner (DC) and Civil Surgeon (CS) of the district, and could get their assurances to remove the shops.

- **A male committee member**

  There were some members in our committee who were not regular in attending committee meetings. I proposed in one of our committee meetings that if any member does not attend consecutive three meetings, h/she should be excluded from the committee members' list. My proposal was included in the meeting minutes to discuss it in the next meeting.

Based on the statement made by committee members and review of meeting minutes, the major health problems were identified (box), and decisions to solve the problems have been implemented. The local health problems dominated the discussions in meetings, and decisions were made in the meetings. Subsequently, the committees took initiatives to implement the decisions. The steps taken to implement the decisions are described in the box.

Problems identified	Decisions implemented
- Low awareness about from where the ESP is available	- A number of awareness-raising meetings with the community people were organized by USCs
- Irregular attendance of service providers and shorter period of stay at H&FWC	- Representatives of TSCs met TH&FPOs, and informed him about the issue
- Unauthorized shops in RD compound created problems for movement and privacy, especially for female patients	- The committee members discussed about the problem with shop owners, and motivated them to remove shops, but had limited success. Then the committee submitted a memorandum to concerned DC and CS, and got assurances to remove the shops
- Reluctance among pregnant women for TT immunization - Wide practice of adolescent marriage	- Stakeholder Committees organized several health-education meetings with the community, and organized a drama on health education
- Service providers charge money from clients for medicines/services at UH&FWCs and THCs	- Committee members met service providers and TH&FPOs
- Require assistance in NIDs	- Committee members worked as volunteers on many vaccination sessions, and were involved in referring children for having oral polio vaccine

Although not prominently, effects of arsenic contamination, supply of insufficient quantity of medicines by the service providers, and service to the poor with respect were also discussed in meetings of both the committees.

Views of ESP users: The FGDs were organized with users of ESP both nearer to and far away from the UH&FWCs of selected unions. Most FGD participants from the near area were aware of the purpose of forming Stakeholder Committees. They informed that some committee members met them after formation of committees. Most FGD participants from the nearer area also reported that the committees were formed to:

- help them improve their health status
- take necessary actions, so that the poor people get health services from the health centres
- work for overall betterment of rural areas

The FGD participants informed that the committees organized meetings in their areas, and they were present in those meetings. They reported that the following issues were discussed in the meetings:

- Importance of antenatal check-up for pregnant mothers
- Personal hygiene
- Nutrition
- Treatment of diarrhoea
- Use of iodine salt
- Importance of use of family-planning methods
- Effects of adolescent marriage
- Types of services and health facilities available
- Advice to send patients to the nearest health facilities timely
- Keep the committee members informed if the ESP users do not get proper treatment in clinics
- Advice to send children to schools

During exit interviews, 5% of ESP users informed that the committee members advised them to go to the nearest clinics for essential health services. Although no assessment about the familiarity of ESP users with the Stakeholder Committee members was intended, an attempt was made to get an idea whether the ESP users observed any change in the service facilities as a result of intervention from the committee. The last one year of their visits either to UH&FWC or to THC preceding winter and Eid-ul-Fitr was used as a reference to assist the respondents. Despite the possibility of recall bias, 61% of the ESP users could report a change or improvement in service-delivery before and after the formation of committees. The perceived nature of improvements in the health facility is presented in Table 3.

Table 3. Perceptions of users about improvement in health facilities

Reported areas of improvement	**Percentage of respondents** (n=85)
Cleanliness improved	63
Waiting arrangement improved	70
Waiting time for service decreased	65
Service providing hours increased	67
Availability of service providers increased	76
Behaviour of service providers improved	68
Sufficient medicines provided	38

Very few participants of FGD from the far area had knowledge about the committees. Some FGD participants preferred to go to pharmacy or village doctors, instead of going to the government health facilities, for treatment for the following reasons:

- Non-availability of service providers at health facilities
- Service providers did not provide sufficient (full doses) medicines
- Service providers misbehaved with clients, and charged money for treatment

The following case study reflects the demand for money for services and misbehaviour by the service providers:

- **A female FGD participant**

  I was suffering from a female disease (*meyeli ashuk*), and went to our union hospital for treatment. After hearing my problem, the female doctor told me to give her Tk. 300.00. I told the doctor that I do not have so much money, and I agreed to give her Tk. 100.00. Finally, the doctor gave me medicines worth Tk. 100.00. I came back to my home, and took the medicines, but I was not cured. So, I went to a village doctor again for treatment. The village doctor gave me medicine worth Tk. 20.00. I took the medicine, and was cured. After that I never went to that hospital neither for me nor for any of my relatives.

Views of thana managers and service providers: The TH&FPOs reported that, after the formation of Stakeholder Committees, the representatives of members visited the THCs several times, and wanted to know about staff strength, number of doctors, availability of staff, non-availability of service providers at the health facilities, patient load, and stock of medicines at the THCs, which was little embarrassing. Two of four TH&FPOs and one MO of a UH&FWC reported that they did not receive any instruction or order from their authority about the committee activities or to cooperate with the committees. However, all of them were aware of the committees. One TH&FPO reported to have attended meetings of TSC.

After the formation of committees, the members decided to hold meetings with the service providers of their respective area to ensure better coordination between them and to get to know each other. Two thana committees held such meetings, and the list of members was sent to the service providers in other two thanas. About 60% of other service providers reported that they were aware of the formation of committees. Most of them reported that some members met them formally, and some did not follow any schedule. Occasionally, the members met service providers to inform them about the committee activities, non-availability of service providers at the UH&FWCs, local health problems, and problems faced by the service providers in providing services. One FWV reported to have attended a meeting of USC.

In response to a question with regard to facing of any problems with activities of the committees, the service providers reported that the committee members interfered too much in their activities, and insisted to provide sufficient medicines to clients when they come for monitoring visits. The UH&FWCs had a short supply of medicines.

Some service providers reported about some positive changes in terms of client flow in the UH&FWCs occurred in their working areas after starting the committee activities. They added that, after the formation of committees, the majority of clients who visited the health centres were female and from the poor groups. One MA reported that he had to be punctual to keep the UH&FWC open for an extended period of time.

Usefulness of Stakeholder Committees

The Stakeholder Committee members, thana managers, and service providers of MOHFW provided their views on the formation, extent of representation, number of members and usefulness of Committees, and on the role of facilitating NGOs.

Committee members: The members viewed that the facilitating NGOs played a vital role in the formation of Stakeholder Committees and in implementation of their activities. They added that facilitation from the NGOs was needed to continue the committee activities to provide:

- Technical support for better performance of committees
- Secretarial support to committees
- Necessary financial support to committees
- Support in establishing linkages with district and national levels

About 80% of the Stakeholder Committee members stated that the NGOs having a health programme should be involved in facilitating the committee activities. They also added that the NGOs currently working on advocacy of human rights should not be facilitators because of their varied nature of operation in the community and limited experience with the functioning of heath service-delivery. More than half of the members stated that the number of committee members was not sufficient. They reported that the number of members for the TSC should be 15-20, and for the USC it should be 11-15. Some members felt that the committees should also include providers of health and family-planning services.

Service providers: In response to a question with regard to awareness of the purpose of forming committees, the service providers stated that the committees were formed to:

- Create awareness among the rural people about health status
- Motivate people to go to nearest facilities for health services
- Help poor people get health and family-planning services
- Assist thana and union-level GoB and NGO service providers for improving ESP programme

Some of them were quite skeptical about the purpose of forming the committees. They felt that the committees have been formed for the interest of facilitating NGOs. To strengthen and improve the Stakeholder Committee activities, the service providers suggested obtaining formal instruction from the MOHFW describing how to cooperate with committee activities. They also suggested inclusion of the service providers as members in the committees to facilitate discussions between the committee members and the service providers regularly to solve the local health problems jointly.

Activities of Previous Committees

The committee members, thana managers, and service providers were asked to describe their experience on the effects of Stakeholder Committees and previous committees. Comparison of impacts of the Stakeholder Committees and the past committees should be made with caution, since systematic data are not available.

One of the basic differences between the two committees was the composition and mode of operation. Almost half of the Stakeholder Committee members were poor and women, and NGOs acted as facilitating agencies to carry out the committee activities. The past committees did not include users of services, including the poor and females, and the government guidelines were followed to carry out the committee activities. There was a little scope for users of services, including the poor and females, to raise their voices on issues directly affecting their lives and to serve as watchdogs. The

current status of previous committees is reflected from the following statements of the MOHFW officials who were the key members of the committees:

The members of the previous committees stated that the activities of the committees were not currently carried out. One TH&FPO informed that only one MCH coordination committee meeting was held during the last one year. The TH&FPO stated that they were expecting an instruction from their higher authority about the functioning of these committees after the formal launching of HPSP. They were not certain whether the committee activities would continue. No minutes of meetings and other documents relating to the committee activities of the last one year were available. Eighty percent of the committee members reported that the responsible persons did not convene the committee meetings, and most members stated that the committees were not well-organized.

Over 68% of the members did not know if there was any schedule to organize meetings. Thirteen percent reported that the meetings were not held due to lack of necessary funds to meet related expenses. Only 23% of the thana health committee and 63% of the union family-planning coordination committee members could inform that they were not certain whether the committees still exist.

Knowledge of Stakeholder Committee Members

To assess the knowledge of Stakeholder Committee members, information on the purpose of forming the committees, their TOR, and some commonly-used terms of HPSP was collected. About two-thirds of the members had correct knowledge about the purpose of forming the committees and their TOR. About 70% of them were aware of the major issues of TOR. They reported that the TOR was appropriate for the committees.

The extent of familiarity of the members with some commonly-used terms of HPSP is shown in Table 4. About 60% of both male and female members could provide some description about the HPSP. Almost half of them could describe NID, which they reported to have learnt in the monthly committee meetings.

The overall knowledge of the members about all health facilities in their area was also assessed. The knowledge about EPI site as a place for vaccination for children aged less than 5 years and TT for pregnant women and Satellite Clinic (SC) as a place serving pregnant women was higher among the female members than among the male members. This is expected, since it is mostly women who visit the EPI sites for their children and SC for themselves. The knowledge on UH&FWC was almost equal between the male and the female members. Similarly, the knowledge on THC was higher among the male members compared to the female members. The female members had a low knowledge of CC compared to the male members.

Table 4. Knowledge of Stakeholder Committee members on commonly-used terms of HPSP

Common terms	Response	Percentage of respondents	
		Male (n=46)	Female (n=31)
HPSP	Integrated health and family-planning services implemented by the government	58 (27)	58 (18)
NID	A day for providing polio vaccine and vitamin A for children	50 (23)	48 (15)
Health facilities			
EPI site	A vaccination centre for providing vaccines to children aged less than 5 years and TT vaccines for pregnant mothers	39 (18)	45 (14)
Satellite Clinic	A place in a village where female doctors sit and check up pregnant mothers	43 (20)	58 (18)
UH&FWC	A centre/hospital in a union for providing family-planning services	50 (23)	48 (15)
THC	A hospital in a thana for family- planning services and safe delivery	52 (24)	45 (14)
Community Clinic	A small hospital for 6,000 population of a village	67 (31)	32 (10)
Reproductive health			
RTI	Infection in the genital area of females	24 (11)	77 (24)
STD	A bad disease	78 (36)	23 (7)
AIDS	A severe disease which has no treatment	61 (28)	39 (12)
HIV	A germ that causes AIDS	63 (29)	39 (12)

Figures in parentheses indicate the number of respondents

The female members had better knowledge on RTI than the male members. The low knowledge of male members reflects the commonly-focused awareness-raising effort on RTI as a disease of mostly females. STD was viewed as a bad disease by 79% of the male and 23% of the female members. The members knew about the term AIDS as a dreadful disease for which there is no cure and viewed HIV as a germ causing AIDS, and the knowledge of the male members was higher than the female members.

Involvement of Stakeholder Committee Members with other Committees and their Sociodemographic Characteristics

To assess the exposure of Stakeholder Committee members on any development activities, information on their involvement with any other committees was collected. More than half of the total members was involved with the rural development committee

initiated by the Bangladesh Rural Development Board (BRDB) and local NGOs, school managing committee, thana development committee, and women development committee.

Data on the sociodemographic characteristics of members were collected to examine representation of the poor socioeconomic group and females in the committees (Table 5)**.** The union committee members were relatively young and were in their mid-30s, while the members of thana committees were in their early 40s. No major differences about the representation of females in both the committees were observed. The overall literacy rate was higher among the members of thana committees than among the members of union committee. Sixty percent of the thana committee and 22% of the union committee members had higher secondary grade education. Fourteen percent of the union committee members had no formal education. The proportion of owners of cultivable land was higher among the union committee members. Six percent of both the committee members were landless.

Table 5. Sociodemographic characteristics of Stakeholder Committee members

Variable	**Thana** (n=28)	**Union** (n=49)
Mean age (in years)	41	34
Sex		
Male	59	61
Female	41	39
Literacy status		
Never gone to school	0	14
Primary (1-5-year schooling)	11	27
Secondary (6-10 year schooling)	29	37
Higher secondary (>11 years schooling)	60	22
Land-holding status		
Own cultivable land	39	45
Own domiciliary land only	41	49
Own cultivable land and house for rental	14	0
Landless	6	6

Strengths and Weaknesses of Stakeholder Committees

Strengths: The Stakeholder Committees are different from the previous committees in terms of composition and mode of operation. The government determined the TOR of the previous committees, and planned meetings and activities were carried out in a ritual fashion. The previous committees had no opportunity to listen to voices of poor users and women. For the first time, poor users of ESP and females were included in the stakeholder committees. Both poor users of ESP and females had an opportunity to raise their voices in the management of health service-delivery at the local level. All the members, regardless of their socioeconomic status, had an equal opportunity to raise issues and concerns and compelled the service providers to listen to their voices. The

committee activities, along with advocacy on human rights, have been carried out. The members spent time for the committee activities and took part in sensitizing the community on issues that have direct impact on people's lives.

Considering the length of operation of the stakeholder committees and in absence of any guidelines and follow-up support from the NSC, the committees have been working on their own. Although it is difficult to quantify the services, the committees have demonstrated their strength in addressing the commonly-discussed barriers to the quality of care, such as negative attitude/behaviour of service providers, poor interactions between clients and service providers, and lack of essential drugs and supplies in the health facilities. The committees also demonstrated their interest on gender issues, efforts to minimize social barriers to acceptance of TT immunization during pregnancy, and effects of adolescent marriage which give positive impression on the effects of the committees.

Given the current style of management of HPSP, it would be premature to quantify the extent the committees succeeded in establishing transparency and accountability. Both the terms are inter-linked, and the commonly-understood indicators are not readily available. However, the committees ascertained the functioning of THCs and UH&FWCs, and regular availability of service providers in the health facilities. Serving the poor people and women with respect is an indication of moving toward those issues.

Weaknesses: Although the Stakeholder Committees had a balanced representation of different socioeconomic groups and gender, the majority of members were selected from a concentrated area of facilitating NGOs. There was no representation from the whole area of a union or a thana. Forty-one percent of the members mentioned that the committees did not have adequate representation from all sections of the society. The members felt that most of the Stakeholder Committee members were the beneficiaries of facilitating NGOs. They were from particular areas, and did not represent all areas of a union or a thana.

The facilitating NGOs took a major role in orienting and educating the committee members about their responsibilities, TOR, and, to some extent, some important concepts of the HPSP. The involvement and role of NGOs in facilitating the Stakeholder Committee activities were not well-defined. It was not clear whether this role could be sustained. The NGOs did not have any plan to delegate the facilitating role to the committee members.

Despite enthusiasm, the committees encountered several problems for which there were no immediate solutions. It was not clear whether the NSC really played any monitoring role other than endorsing the committees. The committees did not receive the needed support as an authorized body to operate smoothly at the local level. As such, the thana managers and service providers of MOHFW could question the authority of the committees. Although both TSC and USC meetings were held jointly in some thanas, others held these separately. Some committee members had confusion about the committee activities, and thought that supervision and monitoring of the local health facilities and service providers were their main activities. This created some misunderstanding between the committee members and the service providers.

In implementing the committee activities, no uniform procedures were maintained in all thanas due to absence of a manual endorsed by the MOHFW. The manual could help the members to be educated about their roles and responsibilities, how to work for better performance, and delineate the role of MOHFW officials and staff with the committee activities.

Less coordination between the TSC and the USC was observed in two thanas. The USC was more active than the TSC. The TSC in another thana did not inform the USC how frequently they should meet.

Lack of funds affected the implementation of committee activities. The committee members spent money to procure stationeries, such as pens, papers, registers, file covers, etc. and for entertaining the meeting participants. The NGOs provided the money from their own fund to meet the expenses.

Absence of monitoring from any level considerably affected the implementation of committee activities. Both TSC and USC members sent the reports of committee activities to the chairman of NSC. But none of the committees received any feedbacks from the NSC. They also added that nobody from district or national level paid any monitoring visits in any of the study thanas after the formation of committees. This discouraged them to continue the committee activities.

The thana and union-level service providers of MOHFW are not used to question on staff strength, attendance of staff, and status of supplies and logistics from outside normal MOHFW channel. Moreover, these kinds of questions are not in the mindset of thana and union-level service providers. They did not assist in performing the committee activities, and felt too much of interferences. Orientation of the thana managers on the role of the committees could prepare them to face this type of question.

Key Findings

The Stakeholder Committees are different from the previous committees, and have more representation from the community, particularly from poor users of ESP and females. The poor users of ESP and females had an opportunity to raise their voices in the management of health service-delivery at the local level. All the members, regardless of their socioeconomic status, had an equal opportunity to raise issues and concerns, and compelled the service providers to listen to their voices.

Despite the absence of any systematic monitoring support either from the NSC or from the facilitating NGOs, the committees were active. Most committee meetings were held as scheduled, and the attendance in meetings was encouraging, except in two areas. Formal procedures were followed in meetings in terms of topics covered, i.e. agenda, availability of meeting minutes, identification of local health problems, and initiation and implementation of decisions. The committee took steps to implement the decisions of its meetings.

The committees were useful in organizing community-awareness sessions about their health problems, referring patients in the nearest health facilities, and ensuring the availability of service providers for longer hours in the health facilities. The members took notable initiatives to solve the problems after discussing with the service providers.

Reported increase in client flow in clinics after the formation of committees indicates that the committees had positive effects in improving the delivery of ESP.

The Stakeholder Committees did not, however, get necessary cooperation from some service providers as neither the committees had formal authorization nor the service providers received any formal instructions from their authority.

Systematic holding of Stakeholder Committee meetings can ensure the monitoring of performance of local health facilities. The TSC and USC members reported that they sent the reports of committee activities to the NSC, but none of the committees received any feedbacks from any level. No one from the district or national level paid any monitoring visits.

Other committees formed in the past were not functioning well. Neither the committee meetings were held regularly nor the committee activities were well-documented due to confusions among the thana managers. The committees were not well-organized, and the responsible persons did not convene the meetings. Lack of necessary funds hindered the actual functioning. Thus, the usefulness of these committees needs to be investigated.

Considering the length of operation of the stakeholder committees, it is too early to expect any significant change in terms of quality of services, transparency, and accountability. In absence of any guidelines and follow-up support from the NSC, the committees have been working very much on their own. Although it was not possible to assess the level of sensitivity of the members on gender issues, the committees demonstrated their strength in addressing the commonly-discussed barriers.

Recommendations

The Stakeholder Committees were constituted to improve the delivery of ESP at the thana and union levels through systematic monitoring by the community group. But systematic monitoring of the activities in the national programme is yet to be well-established. The Stakeholder Committee members were also not certain about their monitoring role and the extent of limits they can proceed. The thana managers and service providers of MOHFW were not familiar with the activities of committees and with the decisions made in the meetings. They had confusions about the span of authority of Stakeholder Committees. Therefore, institutionalization of a monitoring system by a community group was not in the mindset of thana managers and service providers of MOHFW which required further test, and the indicators must be quantifiable.

There were divided opinions in favour or against the inclusion of service providers in Stakeholder Committees. Any decision to include service providers in Stakeholder Committees merits action research with and without involving service providers.

The members of both TSC and USC were selected mainly from the working areas of facilitating NGOs. Representatives from all the areas of a thana or a union were not ensured. This issue needs to be considered in future.

There were no standard implementation procedures of Stakeholder Committee activities. Different committees followed different styles in implementing committee activities. There was no manual to be used as a reference material in implementing the Stakeholder Committee activities. To strengthen the activities uniformly, a reference manual needs to be developed by the MOHFW.

Necessary funds from the MOHFW to cover related expenses for organizing the committee meetings and implementing the activities of Stakeholder Committees should be available.

The committees should maintain a close linkage with local government bodies for necessary support. The thana and union parishad chairmen of concerned area should be invited to attend the committee meetings to familiarize them with the activities of stakeholder committees and to establish an effective coordination among the committees, local government bodies, and service providers.

The NGOs have been facilitating the Stakeholder Committee activities and providing support to make the committees functional. Although the Stakeholder Committee members significantly contributed to implementing committee activities, the leadership lied with the NGOs. To run the activities of committees by the members themselves, the NGOs should delegate the facilitating activities to the members especially to the poor and women.

For promoting the community's voice for improved health outcomes, the Stakeholder Committees should maintain a close linkage with local women organizations and users. The committees should also make more efforts to raise awareness among users, especially among the poor and women, about sources of health services, services available in the health facilities, and client Bill of Rights, so that the users can demand the services from the health centres.

Absence of monitoring feedbacks from the NSC affected the implementation of Stakeholder Committee activities. Therefore, a mechanism needs to be developed, so that the committees can get regular feedbacks on their activities from the NSC.

Absence of area-specific pre-intervention data and of similar information from the comparison areas prevented to make any methodologically sound comparison of health and the community-related indicators. Therefore, further research with quantitative determinants on baseline situation, process variables, and post-interventions is needed. Involvement of a third party in conducting the baseline survey and designing a monitoring system, and post-intervention data can be considered. A tentative list of the recommended indicators with methodology and monitoring frequency has been attached as Appendix 5. The MOHFW should consider these indicators in the future for this kind of interventions.

The activities of past committees were not functioning well in the study areas. Neither the committee meetings were held regularly nor the committee activities were well-documented. But the performance of Stakeholder Committees was comparatively better than the thana committees. Therefore, further action research may be carried out to find out how the previous committees can be linked to the Stakeholder Committees.

Since partnership with the Civil Society is rather a new concept to many, it needs to be mentored. Although the committee members are passive recipients of health services, they spend considerable time for committee activities. The potential of involving the poor, particularly females, in the committees as a new dimension is worth testing.

Policy Implications

Adequacy of support of the NSC for the local committees was a major concern. The MOHFW needs to develop a mechanism, so that the local-level committees can operate

smoothly, and this will eventually prepare the thana managers and service providers of MOHFW to face users of ESP for their activities.

According to the HPSP, approximately 13,5000 CGs to support the implementation and monitoring of CCs will be formed. The MOHFW has to develop a mechanism how the CGs can be merged with the Stakeholder Committees.

Involvement and role of the NGOs in facilitating the Stakeholder Committee activities need to be well-defined.

The study-findings could neither compare with baseline information nor with any other areas as there was no baseline information or comparison area. Therefore, these issues need to be considered in designing future interventions.

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Appendix 1

Composition of National Stakeholder Committee

1.	Joint Chief (Planning), MOHFW	Chairman
2.	Director (Planning), Directorate General of Health Services	Member
3.	Director (Planning), Directorate of Family Planning	Member
4.	Deputy Secretary (Public Health), MOHFW	Member
5.	Deputy Chief (Health), MOHFW	Member
6.	Representative from Health Economics Unit, MOHFW	Member
7.	Representative from BRAC	Member
8.	Representative from Ain O Shalish Kendra	Member
9	Representative from Bangladesh Mahila Parishad	Member
10.	Representative from Voluntary Health Services Society	Member
11.	Representative from World Bank	Member
12.	Representative from Department of Public Administration, University of Dhaka	Member
13.	Senior Assistant Chief, MOHFW	Member-Secretary

Composition of Thana Stakeholder Committee

Appendix 2

Composition of Union Stakeholder Committee

Appendix 4

Terms of Reference of Thana and Union Stakeholder Committees

1. USC will meet monthly to discuss workplan and activities
2. USC will organize monthly village-level health-awareness meetings to promote client Bill of Rights
3. USC will meet UH&FWC service providers every month to discuss important health issues in the union
4. TSC will meet once every two months to discuss issues at thana and union levels
5. TSC and USC would meet once every three months to discuss issues
6. TSC will meet THFPO once every two months to discuss issues
7. USC and TSC will send monthly reports to NSC on the following:
   - 7.1 Cleanliness of UH&FWC
   - 7.2 Regularity/lack of regularity of clinic hours
   - 7.3 Availability/presence of service providers during work hours
   - 7.4 Use of health services and satisfaction of users
   - 7.5 Availability of supplies/medicines
   - 7.6 User orientation/behaviour of service providers
8. USCs and TSCs will facilitate stakeholder consultations in their areas
9. USC and TSC will disseminate BCC materials, including client Bill of Rights, in consultation with clients and stakeholders
10. USC and TSC will facilitate through orientation and training, and enhancement of capacity of clients and stakeholders for effective participation in implementation and monitoring of HPSP
11. USC and TSC will facilitate monitoring of progress of implementation of HPSP through spot-checks, rapid assessments, review of documents, and consultations with both clients and providers at the local health facilities

Appendix 5

Recommended Monitoring Indicators, Methodology, and Frequency

Indicators	Methodology	Frequency
Thana and Union Stakeholder Committees		
1. Community-level activities		
Number of:		
- Planned committee meetings held	Observation	Monthly
- Any health issues included in workplan	Review of minutes	Monthly
- Times TSC/USC met	Observation	Bimonthly
- Times TSC/USC met with TH&FPO/MO-MCH/SACMO/FWV on health-related issues	Observation	As required
- Reports of TSC and USC sent to NSC	Review of minutes	As required
- Times TSC received feedbacks from NSC	Review of minutes	As required
- Awareness sessions using BCC materials organized by TSC/USC	Observation	As required
2. Transparency		
- Adequacy of supply of medicines	Observation Interview	As required
3. Accountability		
- Timely attendance and regular availability of service providers	Observation	As required
4. Impact		
a. Percentage of adult males and females (20 years +) aware of location of:		
GOB service centers		
- Satellite clinics		
- EPI outreach sites	Survey	Yearly
- Community Clinics		
- UHFWCs		
- THCs		
NGO Clinics		
- Satellite Clinics	Survey	Yearly
- Static Clinics		

Contd...

Indicators	Methodology	Frequency
b. Percentage of household heads aware of: Importance of TT vaccination for: - Pregnant woman - Non-pregnant woman - Effects of marriage of girls aged less than 20 years Place for management of pregnancy-related complications Percentage of household heads having knowledge about: - Arsenic contamination - Impact of syphilis - Impact of gonorrhoea - Impact of AIDS/HIV	Survey Survey	Yearly Yearly
Percentage of households having access to water seal latrines	Service data	Yearly
Demographic - Total no. of households - Total no. of population - Total no. of eligible couples - Total no. of children aged less than 1 and 5 years	Secondary data	Yearly
Child health, immunization, and others - Percentage of children aged less than 1 year fully immunized - Number of children aged less than 5 years treated for any diseases at CC/UH&FWC	Secondary data	Yearly
Reproductive health - Number of pregnant women - Percentage of pregnant women received TT immunization (at least 2 doses and all 5 doses) - Number of pregnant women received antenatal care - Number of mothers received postnatal care	Secondary data	Yearly
Family planning - Contraceptive method-mix - Contraceptive prevalence rate	Secondary data	Yearly
Communicable diseases - Number of TB cases completing treatment - Cases treated for RTIs/STDs	Secondary data	Yearly