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Citizen's Voice in Health Policy and Programming:
Setting Agendas and Establishing Accountability

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The Centre for Policy Dialogue (CPD)*, established in 1993, is an innovative initiative to promote an ongoing process of dialogue between the principal partners in the decision-making and implementing process. The dialogues are designed to address important policy issues and to seek constructive solutions to these problems. The Centre has already organised a series of such major dialogues at local, regional and national levels. These dialogues have brought together Ministers, opposition frontbenchers, MPs, business leaders, NGOs, donors, professionals and other functional groups in civil society within a non-confrontational environment to promote focused discussions. The expectation of the CPD is to create a national policy consciousness where members of civil society will be made aware of critical policy issues affecting their lives and will come together in support of particular policy agendas which they feel are conducive to the well being of the country. The CPD has also organised a number of South Asian bilateral and regional dialogues as well as some international dialogues.*

In support of the dialogue process the Centre is engaged in research programmes which are both serviced by and are intended to serve as inputs for particular dialogues organised by the Centre throughout the year. Some of the major research programmes of the CPD include ***The Independent Review of Bangladesh's Development (IRBD), Trade Policy Analysis and Multilateral Trading System , Governance and Policy Reforms, Regional Cooperation and Integration, Investment Promotion and Enterprise Development, Agriculture and Rural Development, Ecosystems, Environmental Studies and Social Sectors and Youth Development Programme.*** *The CPD also conducts periodic public perception surveys on policy issues and issues of developmental concerns.*

As part of CPD's publication activities, a CPD Dialogue Report series is brought out in order to widely disseminate the summary of the discussions organised by the Centre. The present report contains the highlights of the dialogue on ***Citizen's Voice in Health Policy and Programming: Setting Agendas and Establishing Accountability*** *held on August 18, 2004 at the CIRDAP Auditorium, Dhaka.*

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Dialogue Report on

Citizen's Voice in Health Policy and Programming:
Setting Agendas and Establishing Accountability

1. INTRODUCTION

The Centre for Policy Dialogue (CPD), in collaboration with Columbia University, USA, organised a dialogue titled *Citizen's Voice in Health Policy and Programming: Setting Agendas and Establishing Accountability* at the CIRDAP Auditorium in Dhaka on August 18, 2004. *Professor Rehman Sobhan*, Chairman, CPD presided over the dialogue, while *Professor Rounaq Jahan,* Senior Research Scholar, Adjunct Professor, Southern Affairs Institute, Columbia University presented the keynote paper. *Professor Dr. M Amanullah*, Honourable Member of Parliament (MP) and the former State Minister, Ministry of Health and Family Welfare (MOHFW) was present as the special guest at the event. Officials from the Government of Bangladesh (GoB), development partners (DPs), non-government organisations (NGOs), academia, professional organisations, private sector, and the media participated in the dialogue. A list of participants is annexed (Annex 1).

Dr. Debapriya Bhattacharya, Executive Director of CPD, welcomed the dialogue participants and noted that this was the third in a series of dialogues, which CPD in collaboration with Columbia University had hosted since 2002. The current dialogue was designed to review the state of civil society participation in the health sector in Bangladesh.

Professor Sobhan introduced the key themes of the discussion. He stressed that the main focus was to bring together members of civil society to address their responsibility in the design and oversight of health policies. *Professor Sobhan* argued that the traditional notion of exclusive agency of the state in the making and overseeing of public policy was somewhat outdated and emphasised the critical role of civil society in intermediating between the broader constituency of the population and the policymaking establishment of the polity. He then invited *Professor Jahan* to present the keynote paper highlighting the major points for discussion.

2. KEYNOTE PRESENTATION

In her presentation *Professor Jahan* noted that the two major objectives of the CPD/Columbia University (CU) Dialogues are:

- Facilitation of public discussion initiated by civil society for enhancing transparency and citizen's oversight in health programmes.
- Capacity building of civil society for demanding accountability and improving quality of as well as the access to services, especially for marginalised groups.

2.1 Key Messages from Previous Dialogues

The current dialogue is the third in the series of CPD/CU dialogues on health policy and programming. The first dialogue in 2002 focused on community and stakeholder participation and brought representatives of community based "stakeholder committees" to discuss and debate their experiences with the health system for the first time at the national level. The emphasis of the second dialogue, held in 2003, was women's health and health systems. Several key messages emerged from the previous dialogues.

- Despite the lack of government support, effective community participation and oversight improves quality, access to and utilisation of services.
- Communities and non-government groups face obstacles in engaging with official processes and in demanding accountability from the health system.
- Government initiated community and stakeholder consultation processes are generally *ad hoc* in nature and are not sustained beyond the design phase of policy / programmes.
- The consultative processes lack an effective system of feedback.
- Most of the time consultations are limited only to a small number of groups, making the widening of the circle challenging.
- Citizens mostly remain uninformed about the government-Development Partner (DP) negotiations that frequently lead to policy/ programme shifts.
- There are only limited initiatives by citizen's groups to demand accountability. In order for citizens to engage the system they must have stronger political and legal support.
- The voice of the provider organisations, such as Bangladesh Medical Association (BMA) is stronger than the voice of the consumer organisations.

2.2 Summary of the 2004 Dialogue

Professor Jahan then noted the rationale behind the current dialogue. The session was organised at a time when MOHFW and the DPs were negotiating funding for the Health, Nutrition, Population Sector Programme (HNPSP) (2003-2006) and the Strategic Investment Plan (SIP) (2003-2010). This was a critical time because GoB and DPs had again started negotiations after being deadlocked for more than two years. Coincidentally and simultaneously this dialogue was organised to engage civil society in the GoB –DP conversations. However, information about HNPSP and SIP has been limited to a few NGOs and civil society organisations (CSOs), though they require wider public information, scrutiny and debate. SIP plans to introduce new reforms and programme elements, including a different financing mechanism, which would result in a shift in the role of the public sector. Citizens need to be consulted when such policy shifts are being contemplated.

The two major objectives for the current dialogue put forth by *Professor Jahan* are:

- Creating a space for civil society to discuss the SIP, which was being negotiated between the GoB and the DPs, and provide civil society feedback.
- Discussing the policy support and institutional arrangements needed to ensure citizen's voice and oversight in health policy and programming.

Professor Jahan identified four major concerns for discussion and debate at the dialogue.

- *The role of elected bodies*: In order to represent the citizen's voice, elected bodies such as the Parliament and the Union Parishad, should act as effective checks on the executive branch and be major platforms for policy debates. This is paramount because historically Bangladesh's executive branch has had more power.
- *The role of non-government groups*: In order to embody citizen's voice, NGOs and CSOs should represent and lobby for marginalised sections of the population and independently critique the performance of the government. In a democracy, the government is not the sole entity representing citizens. Civil society is a fundamental component of a democratic system, and has a legitimate role of representing diverse viewpoints.

- *Autonomy of non-government groups*: The independence of non-government sector is very much necessary for the amplification of citizen's voice. However, in Bangladesh, the NGOs are primarily dependent on government and DPs for funding which limits their autonomy. In addition, long-term institutional programme funds are unavailable making it difficult for NGOs and CSOs to sustain their own agendas.
- *Effective engagement between government and non-government sector*: There is a lack of sustained dialogue and effective partnership between the government and NGOs due to a lack of space for constructive criticism.

Professor Jahan proposed three major issues for discussion and debate:

- Lessons from past experiences of incorporating citizen's voice.
- Reflection of citizen's voice in HNPSP and SIP.
- Improving effective citizen participation.

2.3 *Issue 1*: Lessons from Past Experiences of Incorporating Citizen's Voice

Professor Jahan summarised the key lessons from past attempts to incorporate civil society's voice and to facilitate the consultation process with communities and stakeholders. She observed that NGOs had been involved in the health and population sector since the 1970s, mostly in raising awareness and providing services. In the 1980s, NGOs, such as Gonoshasthya Kendra (GK) started to get involved in health policy advocacy, as exemplified by the National Drug Policy (1982) and the abortive National Health Policy (1990). In the mid-1990s, when the government and DPs started negotiations about major health sector reforms, both recognised the need for widespread community and stakeholder consultation.

A Health and Population Sector Strategy (HPSS) and a five-year (1998-2003) Health and Population Sector Programme (HPSP) were designed in 1996 and 1998 respectively, after nation-wide consultations with thirty-four different categories of stakeholders conducted over a two-year period. Seventeen task forces with members drawn from GoB, DPs and civil society worked during this period to develop different elements of HPSP. The Programme Implementation Plan (PIP) of HPSP also specified institutional arrangements for community and stakeholder participation in monitoring and review of the programme.

A National Stakeholder Committee (NSC) was established. Focus was also given to service users through formation of 25 pilot community based primary Stakeholder Committees. Community management was emphasised in community clinics and stakeholder participation was to be present in the Annual Programme Review (APR).

During the design of HPSP, MOHFW invited NGOs and CSOs such as BRAC, Nijera Kori, Mohila Parishad, Nari Pokkho, and VHSS, to participate and facilitate the consultative process with communities and stakeholders. Several non-government groups such as Transparency International also started their own initiatives to monitor the work of the health services. In addition to HPSP's own allocated funds, various development partners such as DFID, Danish International Development Agency (DANIDA), United Nations Children's Emergency Fund (UNICEF), provided additional resources for citizen's voice.

However, elements of community and stakeholder participation were not prioritised during the implementation of HPSP. The National Stakeholder Committee (NSC) hardly ever met. Twenty-five community based stakeholder committees were formed in pilot unions and Upazilas but they did not receive official support. The strategy on stakeholder participation was also not developed due to low prioritisation placed on the consultative process. APR did not systematically include citizen's voice.

Again, HNPSP (2003-06) was designed with community and stakeholder consultation and proposed several activities for stakeholder participation in its PIP. It is yet to be seen how far these participatory activities would be implemented.

Professor Jahan then summarised the lessons that emerged from the past experiences:

- Citizen's voice is generally incorporated in the design of a policy or a programme (e.g. HPSS, HPSP, and HNPSP) when government and DPs are committed, allocate time and funds, recruit staff, and engage with non-government groups who have access to community and represent the voices of excluded groups. Without this multifaceted commitment, citizens will not be integrated into policy / programme design.

- Government and DPs tend to show commitment to citizen's voice during the design of a policy / programme but that commitment is not sustained during the implementation phase, particularly in the monitoring and review of the programme. Implementation of HPSP is a good example of this phenomenon where government was responsible for organising stakeholder consultations, but failed to do so in a systematic manner.
- Non-government groups are successful in interacting with the health system in different places but their voices are trapped at the local level and are not heard at the national/central levels. The responsiveness of the system depends on the personality of the local level service providers/managers. There is no systematic mechanism which service users can utilise to enforce the accountability of the health system.
- There is no mechanism present through which non-government groups can impact central decision making in the health sector.
- Elected representative bodies, such as the parliament, have not engaged in any serious debate about various policy options in the health sector thereby limiting the extent to which citizen's groups can use the Parliament as an accountability mechanism.
- Non-government groups in the health sector do not have an effective forum at the national level to represent citizen's voice and for sustained advocacy and engagement with the government and the DPs. However, in the education sector, Campaign for Popular Education (CAMPE) has been effective in bringing together different organisations to monitor the sector by acting as a forum, engaging in institutional development, research, monitoring, evaluation, and documentation.
- There is an absence of institutional and flexible funding, which limit the capacity of non-government groups to sustain advocacy work.

2.4 *Issue 2*: Citizen's voice in HNPSP and SIP

Citizen's voice has been recognised as being relevant in the design phase of both HNPSP and SIP. The Project Implementation Plan (PIP) of HNPSP recognises the importance of community and stakeholder consultation in making services responsive, effective and need based. The PIP proposed several activities to strengthen consultation with communities and stakeholders, for example, the development of a stakeholder strategy and translation of the strategic actions into operation plans; "local level planning;" collaboration with other existing forums to avoid duplication; "training health service

providers to be sensitive to the users' voice;" and training users, particularly the poor and women, to be more effective in participation. Implementation responsibility for stakeholder participation was given to respective line directors.

The proposed SIP notes commitment to citizen's voice and promises organisational mechanisms and representation of the poor in local level planning and stakeholder consultation. While the SIP identifies citizen's voice in a few key strategic areas such as decentralisation, there are still opportunities for greater incorporation of citizen's voices in additional areas.

2.4.1 Strategic Investment Plan (SIP): Objectives and Strategies

Professor Jahan provided the participants with a summary of the key objectives and strategies of the proposed Strategic Investment Plan (SIP). SIP has established five priority objectives for the Health, Nutrition and Population (HNP) services.

- Accelerated reductions in maternal and neonatal mortality and in maternal and child malnutrition: SIP emphasised six strategic interventions to achieve this objective. These are: investing in information, education and communication (IEC) campaigns; scaled up training of skilled birth attendants; new-born-care practices; health care voucher programmes for demand-side financing; public sector Emergency Obstetric Care (EOC) facilities; and lastly National Nutrition Programme (NNP) type community nutrition programmes. However, some interventions, such as the healthcare voucher programme, are new elements and require further discussion.
- Rapid reduction of Total Fertility Rate (TFR): Four interventions have been noted for meeting this objective. The first intervention is IEC, quality improvement, and method-mix. Secondly, facilitation of selective outreach programmes to respond to unmet needs; thirdly, later marriage and delayed age at first birth; and fourthly, alternative roles for adolescent girls have also been noted as interventions. Unfortunately, methods directed towards males, including condom use, which could provide dual protection against pregnancy as well as HIV/AIDS, were not highlighted.
- Reduction of the injury induced high death toll: In order to meet this objective, SIP stressed four major interventions. SIP firstly gave importance to public information campaign for improved road, water, industrial and domestic safety. Secondly, it

called for investment in emergency facilities and thirdly, publicly financed insurance for in-patient emergency treatment. Lastly, medical counselling and legal aid to female victims of violence were also seen as strategic interventions.

- Reduction of the burden of TB, Malaria and other communicable diseases: In order to fight communicative diseases, especially TB, SIP called for two major interventions including increased case detection and maintenance of high cure rate along with human resource development (HRD). In the case of Malaria, the five interventions noted were: early diagnosis and prompt treatment; selective vector control; promotion for insecticide-treated mosquito nets (ITMNs); epidemic preparedness and response; and community involvement and public-private sector partnerships.
- Ensuring improved public health interventions including the prevention and control of non-communicable diseases (NCDs): The five key interventions for meeting this objective were measures such as burden-of-disease and common risk factor assessment for non-communicable disease; IEC campaign; improved screening for obesity, hypertension and diabetes; improved diagnosis and management; and publicly financed insurance against emergency treatment costs.

Professor Jahan also summarised the six medium-term strategies that SIP had proposed to achieve its priority objectives.

- *Decentralisation and local level planning*: In a decentralised administration, local level planning is instrumental to facilitate consultation with stakeholders, local government, and communities in the public policy processes. SIP proposed decentralisation to ensure accountability for agreed contributions to HNP sector goals and targets. SIP also proposed decentralisation in budgeting related to local level planning (e.g. six pilot districts). However, and quite significantly, decentralisation is not always successful and it is important to draw on lessons from other countries to ensure its success and sustainability.
- *Diversification in service provisions while ensuring service quality*: To improve quality in service provisions through diversification, SIP placed considerable emphasis on proposed contracting to NGOs and private sector and collaborating with professional bodies, private providers and NGOs to improve service quality.

- *Expanding demand-side financing initiatives*: MOHFW has planned to conduct a pilot on vouchers scheme for the purchase of maternal health services. Upon evaluation of the pilot, it would expand its demand-side financing.
- *Improving budget management*: SIP proposed to sponsor a needs-based resource allocation programme in which it emphasised consolidating responsibility for budget preparation. Its focus for an improved budget management relied upon a provision of rolling medium-term financial plans, which would match projected expenditure and resource envelopes.
- *Improving sector management*: As part of the strategy, SIP proposed to bring improvements in planning functions, reform management, aid management, and management of contracts and commissions with private and NGO providers.
- *Bringing improvement in aid management*: SIP considered ministry-led aid co-ordination as an important part of the strategy. While proposing 'base-level' DP financing for core HNP programme costs, SIP proposed complementary performance-linked financing. It also sought improvement in aid management through invoking different financing modalities for DP contributions to recurrent and investment expenditures.

Professor Jahan pointed out that SIP misses the important strategy of evaluating how public sector service provisioning will improve in this process. There is also no mention in the SIP about what essential services will be given in the public sector, as was done with the previous HPSP.

Professor Jahan noted that SIP constructed a set of strategic performance indicators for sector modernisation. These indicators were to be revised after further discussion and later aligned with PIP indicators. Four sets of indicators – *outcome; output and efficiency; process; and input* – were constructed with 2003 as base year and 2010 as target year. These indicators have been annexed (Annex 2).

2.4.2 Reflection of Citizen's Voice in SIP

SIP had emphasised the government's commitments to citizen's voice and promised to build on previous experiences to further develop effective organisational mechanisms to improve citizen's voice and ensure representation of the poor in local level planning and

stakeholder consultations. However, SIP did not elaborate on any strategic action to strengthen citizen's voice. *Professor Jahan* commented that several reform measures and new programme elements that SIP introduced require wider public scrutiny and debate, and greater community engagement and oversight. For example, programme elements such as diversifying service provision through contracting to NGOs; demand side financing; decentralisation and local level planning; improving sector management; and elaborating performance indicators, would all require community engagement and oversight. *Professor Jahan* pointed out that the strategic performance indicators of SIP clearly neglected to include citizen's voice. She believed that the reform measures and programme elements of the SIP needed to be further detailed in consultation with a wider group of stakeholders including service users.

2.4.3 Additional Areas for Inclusion of Citizen's Voice

Professor Jahan asserted that SIP clearly did not provide required space for citizen's voice and identified certain areas that were central for accommodating citizen's voice in health policy processes and HNP services in Bangladesh.

Firstly, she suggested that citizen's voice could be accommodated in the programme element of diversification of service provision by including representatives of poor service users in local level committees that scrutinise NGO/private sector contracting. Citizen's voice can also be magnified through establishing and strengthening consumers' associations, which could improve quality of services and create an accountability mechanism to monitor service providers.

Secondly, citizen's voice can be further incorporated in the programme element of demand-side financing. Citizen's oversight could be effective in checking corruption in different demand-side financing schemes, such as the voucher scheme.

Thirdly, citizen's voice can also play a role in improving sector management. It could contribute to improving reform management through sustained consultation with stakeholders, which will also mobilise constituency support for reforms.

Fourthly, citizen's voice could be incorporated into the strategic performance indicators. Community and stakeholder participation should be included as a process indicator in the SIP's strategic performance indicators.

2.4.4 Questions for Discussion and Debate

Professor Jahan put up several questions for debate on SIP's objectives, strategies, and performance indicators and invited participation from the audience. She presented the following questions in order to guide the discussions and debate in the dialogue:

- Objectives*:* While the SIP emphasises interventions in communicable diseases, it also includes interventions for non-communicable diseases (NCDs). Should the public sector resources be spent for control of non-communicable diseases, as these would be too costly and may not be diseases of the poor?
- Strategies*:* Are the six strategies adequate to reach the SIP objectives? Should there be more emphasis on strategies for reforming the public sector, which is the major health service provider in the country?
- Performance Indicators: Are the two process indicators (i.e. districts with some delegated budget responsibility and contract management capability in the MOHFW) adequate for meeting the SIP objectives? Should there be other indicators?
- What additional actions are needed to strengthen citizen's voice in HNPSP and SIP?
- What will enable non-government groups to initiate and sustain their own dialogues with government and DPs?

2.*5 Issue 3*: Effective Citizen's Voice

The third issue for discussion and debate was the enhancement of the effectiveness of citizen's voice outside the government bureaucracy. While non-governmental groups and the media had been highlighting consumer's concerns and plight, they had not been able to get adequate policy response from the government. There is a need to strengthen citizen's voice outside the government bureaucracy.

Professor Jahan maintained that there were three actors who could play an important role in this regard. There is a need for a proactive role of the Parliament. The Parliamentary Committee on Health should enhance its role as the mechanism through which policy

debates take place and scrutinise policy/programme options in HNP sector. The Committee should also hold public hearings on HNP sector once a year for example.

Secondly, autonomous civil society groups could also play an important role. Civil society groups need to strengthen their capacity for evidence-based advocacy. They should also form alliances with wider number of groups around common agendas and lobby the government addressing problems but also involving themselves in the policy oriented solutions. A multi-institution and common-cause alliance approach is necessary in order to effectively ensure citizen's voice in health policy discussions. However, *Professor Jahan* argued that civil society organisations face a serious dilemma: while they needed to maintain independence from government and DPs in setting their agendas, they are dependent on the same government and DP sources for funding.

The media was identified as the third and the most important actor in enhancing the effectiveness of citizen's voice. While civil society could use media as their major vehicle to involve in advocacy activities, media itself should be proactive. *Professor Jahan* proposed that the media should publish investigative reports and conduct campaigns on priority issues. At the same time, media must ensure that they disseminate correct information. In order to be effective, both civil society and media need access to official documents and processes. Official documents produced by government and DPs should be placed in the public domain so that citizens can have informed opinion on policies that eventually affect their lives.

2.5.1 Questions for Discussion and Debate

Professor Jahan highlighted the following question for debate and discussion:

- What are specific suggestions to strengthen citizen's voice independent of government and DP bureaucracy?

3. DISCUSSION AND DEBATE

The Chairperson, *Professor Sobhan,* initiated the discussion by noting that the SIP is a new policy document that had not yet been made public. He asked the participants to dwell primarily on the overarching question *Professor Jahan* had raised in her presentation – that is how to bring civil society voice into policy formulation as well as into the process of oversight of policy implementation.

In order to have a more informed and involved discussion, *Professor Sobhan* called upon those participants who had been consulted by the GoB and the DPs during the preparation of the SIP to speak first. It appeared that among the audience, only GoB and DP representatives were consulted and none from civil society were involved in the SIP preparation process. *Professor Sobhan* remarked that this was indicative of the fact that major public policy initiatives in Bangladesh seldom involve consultation with civil society and citizens though policies are supposed to be intended for citizen's benefits.

3.1 Current Status of SIP

Dr. Zahiruddin Ahmed, Director of Planning (Directorate of Family Planning), MOHFW, drew attention to the premature nature of SIP. The SIP was still under the process of preparation and negotiation. In fact, the version of the SIP to which the keynote presentation referred was not actually an approved version. *Dr. Ahmed* emphasised that until and unless the GoB made a final decision on the programme, the role of the citizens, the private sector, or the NGOs could not be explored. He mentioned that the very day when the dialogue was taking place, the GoB and DPs had a wrap-up meeting on the SIP. While defending the position of the GoB, *Dr. Ahmed* noted that the SIP would finally be a simple and concise document consisting of about 40 pages. The detailed ideas regarding the SIP could be found in 37 Operational Plans (OPs) in the health sector that had been approved last June. The Executive Committee of the National Economic Council (ECNEC) had also approved the PIP (2003-2006) of HNPSP. He added that the GoB, as recommended by the DPs, was considering the organisation of massive dissemination seminars to inform citizens and stakeholders about the SIP. He also pointed out that constitutionally it was the government who should be responsible for responding to the

demands of the people, and the present government had been keen and careful in that respect while designing the HNPSP.

Mr. Kees Kostermans, from the World Bank and team leader of the Pre-Appraisal Mission for SIP, informed the audience that most of the major DPs were in a process of negotiation to form a joint support for the health sector of the country for the next five years. The SIP provided them with the framework for acting in this regard. The DPs who formed the Pre-Appraisal Team were Asian Development Bank (ADB), Canadian International Development Agency (CIDA), DFID, German Technical Cooperation (GTZ), KFW, European Community, German Embassy, Japan International Cooperation Assistance (JICA), the Swedish Embassy, Swedish International Development Agency (Sida), USAID, UNICEF, United Nations Population Fund (UNFPA), and the World Health Organization (WHO).

Professor Jahan, in response to the observations by the representatives of the GoB and the DPs, reasserted her position in regard to the need to incorporate citizen's voice in the SIP before the document is finalised. Contrary to the observations of *Dr. Ahmed* and *Mr. Kostermans, Professor Jahan* contended that the policy documents such as SIP should not be made final until civil society, NGOs and other stakeholders had been adequately consulted. She argued that once such policies were finalised, consultation with civil society seldom made any difference.

3.2 Citizen's voice in SIP

Professor Jahan's observation that the policymaking process in Bangladesh has not recognised civil society as an important partner and does not adequately consult them, provoked considerable discussion. *Professor Dr. S. M. Akbar,* MP, agreed with *Professor Jahan,* and expressed his regret for the fact that consultation with civil society had not taken place in preparation of programmes such as SIP.

Dr. Syed Jahangeer Haidar, representing Research Evaluation Associates for Development (READ), added that the involvement of civil society, if present, remained at the levels of being members of coordination committees, consultative committees, seminars and workshops. He raised the important issue of the absence of civil society

involvement in tender committees, procurement committees, the budget committees, the allocations committees, and the ECNEC. He agreed with *Professor Jahan's* observation that "civil society" is not adequately connected with the marginalised population who were the actual users of public sector services, and felt it was necessary to establish such links. *Dr. Haidar* also asserted that a solid strategy was needed to reach the poor, which could be effectively ushered by SIP.

Mr. Samson H. Chowdhury from Square Pharmaceuticals also highlighted the need to reach out to the grassroots level. He believed that before any policy was made final it was imperative to hear from the people who were actually suffering.

Dr Syed Akram Hossain of Bangladesh Medical Association (BMA) pointed out that whenever the government made any policy document, there was limited stakeholder participation, and the making of SIP was not an exception. He noted that the BMA had tried to participate during the preparation of HNPSP with a concept paper and a series of recommendations, but it did not receive cognisance from GoB. *Dr. Akram* added that the BMA had worked with 20 committees around 4 themes to provide recommendations to the government about HNPSP, but the government had ignored their recommendations.

Dr. Neil Squires, Chief of Health and Nutrition Programme, DFID, explained that he had a different interpretation of the issue of citizen's voice in SIP. He stated that the SIP needed to be seen in conjunction with the Project Concept Paper (PCP) and the PIP of HNPSP as SIP was never designed to be a stand-alone document. *Dr. Squires* noted that consultations with civil society had taken place during the PIP and PCP preparations. He pointed out that various documents incorporating civil society consultations had been fed into the preparation of SIP. He highlighted the consultation around the concept of NGO pooled finance, which was a mechanism by which independent finances could potentially be provided to CSOs.

Dr Squires also highlighted the problems inherent in the SIP in its provisions for civil society participation. He mentioned that there was a big debate in the NGO community about the organisational structure of a mechanism for financing NGOs, which would provide them with a degree of independence from direct government control. However, the need for such a mechanism had not been clearly stated in the SIP document. NGO

contracting as noted in the SIP would not provide much latitude to NGOs for innovation and development. He suggested that the pooled-financing mechanism might have a Palli Karma-Sahayak Foundation (PKSF) type of model, whereby money could be given to an independent body, which in turn would allocate the resources against some predefined priority areas. This was consistent with the HNP's policy objectives. *Dr Squires* asserted that such a mechanism could be created to allow CSOs, advocacy organisations, and NGOs to apply for financing.

Dr. Squires also suggested that another potential mechanism by which civil society voice could be incorporated was 'demand side financing'. It would provide people with the resources to make choices about the types of health services they want to use. *Dr. Squires* pointed out that "an important aspect of citizen's voice is citizen's choice". He explained that unless citizens could choose to exit services that they found unsatisfactory, they would never have a strong voice. And if the consumers were given the wherewithal, the financial means to pay for services (either from public or private sector), they could then actually make a choice between a poorly performing public sector or a potentially better performing private sector or NGO service provider.

Dr. George John Komba-Kono, Medical officer with the World Health Organization (WHO) disagreed with the earlier observation that there was no arrangement for citizen involvement in SIP. He stated that civil society involvement had occurred in the planning process. He highlighted the usage of participatory rural appraisal method in the programme design and emphasised on local level planning as examples of citizen's voice.

3.3 Human Resource Management

Ms. Tahera Jabeen, Health/Social Development Expert with Northern Ireland Health and Social Care Services (NICARE) noted that human resource (HR) issues were not adequately addressed in the SIP. She believed that a serious commitment was needed from the political community to ensure effective HR management. The professional associations not only affected the health care system but also fettered health care provider's initiatives.

Agreeing with *Professor Jahan's* recommendation for improving the public sector services, *Mr. Kostermans* suggested the need for strengthening the public sector,

especially in the area of HR. He felt that HR was the linchpin of the public sector. If HR was not managed well, it would act as a barrier to successful implementation.

Dr. Zafrullah Chowdhury of Gonoshasthya Kendra pointed out that the major problem in HR management in the health sector of Bangladesh was the absenteeism of doctors. He asked whether BMA could ensure that doctors would be ready to serve wherever they were posted.

Dr. Chowdhury also noted that Bangladesh lacked trained pharmacists and skilled health care providers, especially in women's reproductive health care. In rural areas, about 43% of the health care providers were the small drug vendors. Most of the traditional birth attendants who provided reproductive health care in the rural areas were basically illiterate. He recommended that public medical colleges should take the responsibility of training the pharmacists, traditional birth attendants and other medical service providers, especially those who worked in the rural areas. *Dr. Akbar* further elaborated on this point by observing that in addition to lack of adequate training of the health care providers, the country also lacked a system of oversight for checking whether the health care services were being provided properly with quality assurance.

3.4 Decentralisation

The issue of decentralisation as an important mechanism of bringing citizens into the policymaking process and reaching out to the poor frequently came up for discussion during the dialogue. Among others, *Dr. Chowdhury, Dr. Akbar,* and *Dr. Akram* spoke on the issue. The speakers commented that for the proper functioning of the health system an effective local government system was essential. They stated that solutions to local problems must come from local knowledge and local experience. *Dr. Chowdhury* emphasised that the Upazila system with the Members of Parliament (MPs) as chairpersons of the Upazila Parishads should be reintroduced. He also emphasised that elected women leaders should be empowered to chair local health committees. *Dr. Akram* advocated the empowerment of the Upazila system through decentralisation of financial and administrative power.

3.5 Accountability

Major concerns brought up during the keynote presentation included the need to internalise citizen's oversight into the policy process and for building effective civil society demand for accountability. *Dr. Squires*, reinforcing *Professor Jahan's* analysis of the accountability mechanism in Bangladesh, emphasised the need for a shift in the balance of accountability. He observed that the country was facing a great accountability dilemma. Bangladesh possessed an accountability relationship between the government and the DP's, while a need was present for such a relationship between the government and the population of the country as channelled through the nation's Parliament. He felt that one of the integral questions for SIP was the formulation of a mechanism for shifting the balance of accountability from one of the government to the DPs, on the basis of financing, to the one of the government to its wider population and Parliament.

Some of the participants asserted that local level committees, where civil society could actively participate, would facilitate such a shift in the balance of accountability. *Ms. Najmoon Nahar* of Nari Pokkho suggested that since government committees, such as the Upazila Health Advisory Committee, did not function properly and different local level committees who were working in the health sector lacked the required financial resources for oversight and the authority to demand accountability, civil society should come forward to oversee these committees' activities and ensure accountability at the local level.

Ms. Jabeen emphasised the need to consider some of the best practices in other countries. In Bolivia for example, social auditing had been successful. Such audit reports were shared with common citizens and the local government's budgeting process gives serious consideration and weight to citizen's feedback. She added that in contrast to the Bangladesh scenario, in Rajasthan, India, a law had been enacted to ensure that every citizen has access to public documents.

3.6 Role of Parliament

In the course of discussion, *Professor Sobhan* asked *Dr. Akbar*, Chair of the Women, Children and Health Committee in the previous Parliament (1996-2001), to comment on how parliamentary committees could play an important role in ensuring accountability. *Professor Sobhan* also wanted to know why the members of the opposition party in the

Parliament were not asserting themselves to address the problems of the health system in the country. *Dr. Akbar* stated that Parliamentary Committee on Health could in theory be a good accountability mechanism but at present the committee had been given minimal power. It is primarily a recommending body. He noted that MPs from the opposition party, who were supposed to chair the district committees in their respective constituencies, were never invited to fill these positions because of their membership in the opposition party. He concluded that the committees, both the parliamentary and local level, were not functioning properly. He claimed that sometimes the executive branch hindered the proper functioning of the parliamentary committees by intervening unnecessarily and putting political pressure on the chairpersons of the committees.

Dr. Akbar suggested that allowing media access to its debates and discussions could ensure the accountability of the parliamentary committees. He also added that neither the Parliament as a whole nor the lawmakers of the country were consulted during the preparation of most of the country's public policies. He mentioned that, for example, although he was an incumbent MP with a medical background, he was not consulted or even informed about the SIP.

Dr. Amanullah, the former State Minister for Health and Family Planning supported the comments made by *Dr Akbar* by adding that the parliamentary committees were not functioning efficiently and the country was not running as an active parliamentary democracy.

Dr. Zafrullah Chowdhury asserted that not only civil society but also the legislators needed to be proactive. He observed that the CSOs and community level organisations had a greater role to play in creating pressure for adequate discussion on policy matters such as SIP and other health policy issues at the Parliament.

3.7 Redefinition of Civil Society Organisations

The lack of linkage between civil society and the marginalised population in Bangladesh was noted by a number of participants. The participants contended that there is a lack of independent citizen's voice and civil society organisations are severely dependent on government initiatives. The participants at the dialogue emphasised that the capacity of

civil society organisations must be enhanced in order to have an influential citizen's voice in policymaking and implementation and in promoting accountability.

Mr. Kostermans pointed out that in order to be heard at the policy making level, the citizens needed to organise to offer a systematic review of programmes and thereby put systematic pressure on the GoB. *Dr. Ahmed,* also shared the view that civil society and citizen bodies needed to organise in order to put substantive pressure on the government. *Dr. Komba-Kono* commented that 'civil society' had only remained as a catchall-phrase and no yardstick had been developed to determine the success of citizen's involvement in public policy processes, especially in the health and development sector. He argued that the current notions of civil society and citizen's voice are very similar to those of 'people's participation' of the early 1960s, 'popular participation' of the late 1960s and early '70s, and 'community participation' of the early 1980s. He further argued that when asked in opinion surveys, health had never emerged as the number one priority of the people and hence it never got adequate budgetary allocation.

3.8 Media

Agreeing with *Professor Jahan's* observation about the importance of disseminating correct information, *Mr. Kostermans* commented that citizens needed to be correctly informed so that they can voice their opinions in public forums. He pointed out that journalists play an important role in this process and need to be careful about the validity of the information that they are disseminating to the citizens. In the context of SIP, he noted that the SIP lacked an effective communication and information strategy. The DPs had suggested that GoB should provide a brief SIP mission statement in Bengali so that the common people could be made aware of the strategies and priorities of SIP.

3.9 Shift in Health Policy

The participants observed that in Bangladesh whenever a new government assumed power, it was more likely to bring abrupt changes in public policy, and the health sector was not an exception. Among others, *Mr. Samson H. Chowdhury, Professor Dr. Amanullah* and *Dr. Akram* spoke on this issue noting that such abrupt shifts in policy and programmes with every change in government had been one of the major sources of problems in the health sector of the country.

Professor Dr. Amanullah mentioned that although the Awami League (AL), the party in power during 1996-2001, accepted Health and Population Sector Strategy (HPSS) that was negotiated during the earlier Bangladesh Nationalist Party (BNP) government (1991-1996), as soon as BNP-led coalition assumed power in 2001, the new government abruptly halted the implementation of the five-year (1998-2003) Health and Population Sector Programme (HPSP), which was based on HPSS. Such changes in policies not only destroy the incentive structure for the implementers and service providers, but also disturb a consistent growth of the health sector.

As an example of such a shift in policy, *Dr. Akram* reported that although the previous policy under HPSP unified the health and the family planning services, recently the two service cadres had again been bifurcated by the current regime as part of its new policy. He noted that such abrupt shifts in policies reduced the scope of civil society participation.

3.10 New Approaches towards the Health Sector

Mr. Kostermans stated that health was not just a result of economic development, it also contributed to economic development. Addressing the concern put forth by the keynote presentation about non-communicable diseases (NCDs), he argued that NCDs were not simply diseases of the elite, the poor equally suffered from cancers, hypertensions, and cardiac arrests. *Mr. Kostermans* emphasised that health was the main asset of the poor and that health of the adult population should receive particular attention. If a poor adult did not possess a healthy body, s/he lost almost everything. He argued that since some of the treatments for NCDs were very expensive, government should act proactively in prevention care in this regard. While the GOB could not bear NCD treatment costs for everyone, it could definitely provide nutrition to the younger population that would help them fight against NCDs at a later stage. However, for some cases of NCDs such as cataracts that were not very expensive to treat but can lead to a reduction in quality of life, the government could intervene with its available resources.

Ms. Sabina Rasheed, an independent researcher, said that health needed to be seen with a broader perspective. Health needs of the poor could not be addressed simply in a bio-medical discourse. She mentioned that heath was only one of many other sicknesses in

the lives of the poor, poverty itself being the number one ailment that needed to be redressed.

Dr. Akram proposed going back to HPSP's commitment of unification of the health and family planning services. He added that the recent reversal of policy decision on unification of services had been done without adequate consultation with the professional groups such as the BMA and other stakeholders.

4. CONCLUSION

Professor Rehman Sobhan brought the session to an end with some concluding remarks. He reasserted the point that if the government did not consult civil society, the latter should mobilise public opinion to ensure accountability of the government functionaries. The citizens should not wait until the government called on them. Rather, they should proactively participate in the policy process by taking initiatives to monitor the performance of government facilities. He emphasised that citizen watch groups should voice and report findings of their oversight activities through the media to a wider section of population.

Annex-1

List of Participants

(*in* a*lphabetical order*)

Professor Dr M Amanullah, MP	Former State Minister, Ministry of Health and Family Welfare
Dr Kaosar Afsana	Programme Manager, BRAC Health Programme
Mr Salek Ahmed	Director, Health Research Division, UBINIG
Dr Jahir Uddin Ahmed	Director(Planning & MIS), Directorate of Family Planning
Professor Kazi Saleh Ahmed	Former Vice Chancellor, Jahangirnagar University
Dr Julia Ahmed	Deputy Executive Director, Bangladesh Women Health Coalition (BWHC)
Dr Munir Ahmed	Programme Coordinator, BRAC Health Programme
Dr Yasmin H. Ahmed	Managing Director, Mary Stopes Clinic Society
Mr Sayed Khaled Ahsan	Program officer, SIDA, Swedish Embassy
Professor (Dr) M.S. Akbar	Hon'ble Member of Parliament
Dr Halida Hanum Akhter	Managing Director, Health promotion Limited (HPL)
Mr Touhid Alam	Consultant, UNFPA
Mr Mohammad Alauddin	Assistant General Manager, MIDAS
Dr Sarwar Ali	Former Director &Medical Adviser, Renata Limited
Mr Aminul Arifeen	NPPP (PDS Sub- Program), UNFPA
Ms Ferdous Ara Begum	Joint Secretary, Ministry of Women and Children Affairs
Dr Syeeda Begum	Project Officer (Nutrition), UNICEF
Ms Monica Burns	Consultant, European Commission
Mr Samson H. Chowdhury	Chairman, Square Pharmaceuticals Ltd.
Dr Zafrullah Chowdhury	President, Consumers Association of Bangladesh (CAB)
Mr Zahid A Chowdhury	Arizona State University, USA
Mr Rafael Cortez	Senior Health Economist, World Bank
Ms Corncila Dinter	Project Manager, KFW
Mr Peter Evans	Governance Adviser, DFID
Dr Sukanto SarkerFreza	Deputy Country Representative, Engender Health
Mr Davidson Gwatkin	Mission Member, World Bank
Dr Syed Jahangeer Haider	Managing Director, Research Evaluation Associates for

	Development (READ)
Mr Sayed Abdul Hamid	Assistant Professor, Institute of Health Economics, University of Dhaka
Mr Md. Jahirul Haq	Deputy Chief, Ministry of Women and Children Affairs
Dr Peter Herzig	Health Advisor, Delegation of European Commission
Professor Khondoker B. Hoque	Dept of Management, University of Dhaka
Mr Md.Shahidul Hoque	Scientific Officer, ICDDR,B
Dr Syed Akram Hossain	Executive Member, Bangladesh Medical Association
Dr Monjur Hossain	Project Officer, United Nations Children's Fund (UNICEF)
Dr Ishrat	Nutrition Specialist, Health Sector Team, World Bank
Ms Kazi Eliza Islam	Program manager (Nutrition), Save the Children, UK
Ms Tahera Jabeen	Health/Social Development Expert, Northern Ireland Health and Social Care Services (NICARE)
Ms Shirin Jahangeer	Consultant, HIV AIDS, World Bank
Mr Atiqul Haque Kabir	Program Organiser, Nijera Kori
Mr K M S A Kaiser	Division Chief , SEI, Planning Commission
Mr G M M Mostafa Kamal	General Secretary, Family Planning Officers' Association, Directorate of Family Planning
Dr Enamul Karim	Team Leader, Health & Life Sciences Partnership Consulting
Mr M Hafizuddin Khan	Former Advisor to the Caretaker Government
Dr Halida Hanum Khandaker	Executive Director, Confidential Approach to AIDS Prevention
Dr George John Komba-Kono	Medical Officer, World Health Organization
Mr Kees Kostermans	Team leader, HNPSP, World Bank
Mr Azhar Ali Mollah	Assistant Professor, Institute of Health Economics, University of Dhaka
Mr Abdul Hamid Moral	Assistant Chief, Health Economics Unit, Ministry of Health & Family Welfare
Mr Md. Mahabub Morshed	Director, Voluntary Health Services Society (VHSS)
Dr Nazmoon Nahar	Program Officer, Naripokkho
Mr Dinesh Nair	Health Advisor, DFID
Dr Makhduma Nargis	Consultant, Medicine, Dhaka Community Hospital
Mr Bjoern Osberg	Consultant, EU
Ms Petra Osinski	Adjunct Scientist, ICDDR,B
Mr Frank Paulen	Senior Health Advisor for SIDA, Swedish Embassy

Dr Mahmudur Rahman	Professor of Medicine, Institute of Community Health-Bangladesh
Dr Nafeesur Rahman	Director, National Forum of Organisations Working With the Disabled (NFOWD)
Mr Habibur Rahman	Local Expert, KFW
Mr Rezanur Rahman	Program Organiser, Nijera Kori
Dr Rukhsana Rahman	Gynae Consultant, General Hospital (District Hospital), Tangail
Dr Mamun-ar-Rashid	General Secretary, BMA, Noakhali Branch
Dr Neil Squires	First Secretary, Human Development, DFID
Ms Sabrina Faiz Rashid	Anthropology and Public Health Dept., BRAC University
Ms Shaila Rodrigues	CIDA, Canadian High Commission
Mr Shahrukh Saif	National Programme Adviser, GTZ
Mr Shamsuzzoha	Information Officer, CAB
Ms Meera Shekar	World Bank
Ms Hilary Standing	Consultant, DFID
Mr Tsuneyuki Umetani	JICA
Ms Bina Valaydon	Public Health Specialist, World Bank
Mr Chris Vickery	Consultant, Save the Children, UK
Mr Howard Nial White	Senior Evaluation Officer, World Bank
Mr Mohammad Zakaria	Advisor, Action Aid, Bangladesh
Ms Tania Zaman	Health & Life Sciences Partnership (HLSP) Consulting

List of Journalist (Participants)
(in alphabetical order)

Mr Syed Zahirul Abedin	Chief Reporter, The New Nation
Ms Sheela Afroza	Staff Reporter, The Daily Amar Desh
Mia Masum Ahmed	A.P.O, Bangladesh Betar
Mr Rasel Ahmed	Staff Reporter, ENB
Mr Shamim Al Amin	The Prothom Alo
Mr Prosoon Ashish	The Sangbad
Mr Salahuddin Bablu	Senior Reporter, The Daily Inqilab
Mr Masudul Karim Biswas	TheDaily Bangladesh Observer
Mr Rashidul Hasan	Staff Reporter, The Bhorer Kagoj
Mr Shahin Hasnat	Staff Reporter, Naya Digonto
Mr Ashraful Hoque	Staff Reporter, NTV
Mr Amran Hossain	Staff Reporter, The Daily Star
Mr Elias Hossain	Staff Reporter, The Daily Amar Desh
Mr Kawsar Iqbal	Staff Reporter, Daily Samachar
Mr Saidul Islam	Staff Reporter, News Network of Bangladesh (NNB)
Mr Zahedul Islam	Staff Reporter, New Age
Mr Hamim Ul Kabir	Staff Reporter, The Daily Sangram
Mr Maruf Mollik	The Daily Ajker Kagoj
Ms Badrun Nahar	The Executive Times
Ms Munni Saha	Special Correspondent, ATN Bangla

Annex 2: Strategic Performance Indicators

Outcome indicators	2003 Base Year	2004	2005	2006	2007	2008	2009	2010 Target year
IMR (per 1,000)	56	53.3	50.6	47.9	45.1	42.4	39.7	37
U5MR (per 1,000)	80	76	72	68	64	60	56	52
MMR (per 100,000)	295	287	279	271	264	256	248	240
U5 malnutrition (% underweight)	48	46	44	42	40	38	36	34
Total fertility rate	3.2	3.1	2.9	2.8	2.6	2.5	2.4	2.2
Met need for EOC' (%)	13	17	21	25	29	33	37	41
Met need for EOC[2] (%)	26.5	31	35.5	40	44.5	49	53.5	58
User satisfaction with Government services (%)	54			65			76	>80%
Output and efficiency indicators								
ANC coverage (%)	40	46.7	53.3	60	66.6	73.3	80	86.6
Outpatient case load per ..., per physician posted at ...	?							
Av. length of stay at UHCs (days)	4							
of births attended by skilled personnel	11.5	16	20.5	25	29.5	34	38.5	43
Process indicators								
Districts with some delegated budget Responsibility	-	-	-	6	6	6	9	12
Contract management capability in MoH&FW					Yes			
Input indicators								
Share of government budget allocated to HNP	5%	6%	8%	10%	10%	10%	10%	10%
Budget execution rates	60%	70%	80%	90%	>90%	>90%	>90%	>90%
? Convergence on pro-poor budget allocation norms	60%	65%	70%	75%	80%	85%	90%	>90%
? Convergence on budgets structure norms (personnel share of recurrent budget)	45%	50%	55%	60%	>60%	-		
Share of total HNP spending that is pooled	34%	36%	38%	40%	45%	50%	55%	60%
Share of public spending on priority services (to be defined)								
Proportion of funds budgeted for personal health care and community/public health services reaching Clients		To be established by expenditure tracking study				-		>90%