

# Women in the Lead Monitoring Health Services *in Bangladesh*

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নারীপক্ষ



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# Foreword

The world today is becoming increasingly complex and relatively simpler development aspiration of poverty alleviation has become complicated with a whole range of concerns including economic issues income inequalities to social issues like inclusion and environmental issues like climate change which affect both the rich and the poor people and nations. Participation, transparency and accountability are being seen as common principles which help to navigate the process of coming to consensus solutions. COPASAH (Community of Practitioners on Accountability and Social Action in Health) is a collective of practitioners who have been applying these principles in the field of health governance in different places around the world. Health care is a contested area of governance and public policy action. In many countries, especially in the Global North, it is provided through state support, whereas in many countries in the Global South public services are in disarray and the private sector is flourishing, creating huge inequalities in access and health outcomes. 'Privatisation' and 'fee for service' are a common refrain from many development think tanks, while a case for 'universal health care' is put out by others.

While cost of care and nature of public or private provisioning continues to be matter of public debate, it is undeniable that there is a huge power asymmetry between people, especially poor people in distress and providers. This power asymmetry affects the ability of the poor to access services in their best interests. In many countries communities have themselves come together to negotiate better health care services from the state. In this Case Studies series we wish to highlight some of these organised efforts. These case studies describes the work of colleagues in COPASAH, outlining how they conceptualised, organised and implemented these processes, drawing upon the principles of participation, transparency and accountability.

We hope these Case Studies will serve as stories of hope and inspiration for other practitioners to adopt similar practices while we strive for better health outcomes and for health equity in our common march toward health for all.

# About Authors

Samia Afrin is coordinator of the Women's Health and Rights Advocacy Partnership (WHRAP) at Naripokkho. Naripokkho is a membership-based women's activist organisation in Bangladesh working since 1983 for the advancement of women's rights and entitlements and building resistance against violence, discrimination and injustice.

Sarita Barpanda, Abhijit Das, co-authors of the case study are affiliated to CHSJ (Centre for Health and Social Justice). CHSJ is a civil society organisation working to strengthen accountability of public health systems and health governance through research, resource support and advocacy. It tries to identify ways through which marginalised groups can become effective partners in health service delivery so that utilisation of services and health outcomes may improve through improving the performance of public systems. For more information, see [www.chsj.org](http://www.chsj.org)

## **Women in the lead: Monitoring health services in Bangladesh**

This case study is part of a series of papers commissioned by the Community of Practitioners on Accountability and Social Action in Health (COPASAH).

# Acknowledgements

This case study is the result of collaboration between authors from two countries working in two languages. It was a long and sometimes fitful process, and the discussions on the case study took place across many emails and phone calls, a field visit, as well as quick conversations when the authors happened to meet. Many practitioners are much better at telling their story than writing it, and this case study is a written product compiling many such stories. Some of the value must have been lost in translating lilted Bangla to prosaic English, but we hope that this case study comes alive with the many short stories. We are grateful to colleagues of Naripokkho for facilitating the field visit and arranging interviews with Doorbar alliance members, Nari Dal members and partners associated with the WHRAP initiative. Particular mention must be made of Shireen Haque and U.M. Habibun Nessa for their unstinting support in conceiving and completing this case study.

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# Executive Summary

Naripokkho is the first non-political organisation working on women's rights in Bangladesh. It is a membership-based organisation, which started in 1983. The 110 active members provide the impetus for its work that is executed through networks and partnerships. It works in all the 64 districts of Bangladesh through an alliance named Doorbar where the primary focus is on political empowerment and prevention of violence against women (VAW). Simultaneously, Naripokkho works on reproductive health and rights in partnership with 37 NGOs in 29 districts.

This case study highlights the accountability of the Women's Health and Rights Advocacy Partnership (WHRAP) initiative that is operational in five districts and 14 upazillas or sub districts of southern Bangladesh. WHRAP is a partnership with 16 NGOs. Naripokkho works with these NGOs to strengthen the accountability mechanisms of health systems through a three pronged approach: Women from the marginalised sections are organised into groups at the village level (Nari Dal) and monitor the Community Health Clinics and the Upazilla Health Complexes. As a second step, Naripokkho has trained the functionaries of its partner organisations to conduct monitoring visits in the local District and sub- district (Upazilla) hospitals. As the third strategy, Naripokkho and its partners are working with Members of Parliament, local elected representatives and other members of the hospital management committees to create a participatory and relevant review and planning mechanism.

Naripokkho defines itself as a movement-based organisation that empowers communities with an emphasis on supporting women in fighting for their reproductive health rights and addressing issues related to gender based violence. The WHRAP initiative clearly brings out this dimension of Naripokkho's work where women are negotiating their entitlements directly with health providers and NGOs negotiate with public officials and local representatives for improving the quality of care of services and the accountability of health providers.

The case study is divided into two parts: The first part traces Naripokkho's interest in accountability for maternal health services and provides a brief background of the organisation. The second part has three sections that highlight the activities, outcomes and challenges faced in implementing the three pronged accountability approach.

The case study is accompanied by two Annexures. Annexure –, provides a brief overview of women's health rights issues in Bangladesh and Annexure -II lists the names and work areas of the sixteen partner organisations of the WHRAP initiative.





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# Chapter 1

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## Introduction to Naripokkho



## A. Understanding Accountability

*In 2011, Miriam (name changed), a field worker employed with Save the Children was due to deliver her third child. Her first two children had been delivered at home. During labour, she realised that something was not right, as her placenta did not come out and she was bleeding heavily. Realising a danger, she asked her husband to take her immediately to the hospital. In the district hospital, the doctor realised that Miriam had retained placenta. They removed the placenta but were not able to control the heavy bleeding. The doctor tried to stem the bleeding and gave her a transfusion but her condition deteriorated further and she went into shock. At this point when Miriam was in the hospital for over one day, they referred her to the medical college. With a lot of difficulty, Miriam and her husband reached the medical college. In the medical college Miriam's husband was unable to get the investigations done within the college as it was afternoon and the laboratory was closed; he had to go out and get the investigations done outside in a private hospital. By the time the investigations were completed and the report came Miriam had died.*

The members of Naripokkho, national women's rights NGO of Bangladesh, wanted to understand the key reasons behind Miriam's death. Here was a woman who was not only involved in providing maternal and child health related education to other members of the community, but had been able to identify her own problem and reach the appropriate health centre in time. They asked the providers at the district hospital about the reasons for the way in which the services had been provided. Some of the key concerns that emerged during this audit were

- The gynaecologist in the district hospital agreed that a district hospital must be able to manage a case of retained placenta and felt that a Dilation and Curettage (D&C) procedure was needed. However, due to heavy bleeding she did not want to take the risk and undertake the procedure, therefore at the last minute Miriam was referred to the Medical college.
- It was difficult to avail an ambulance facility with oxygen services available. With a lot of difficulty, Miriam's husband finally managed one and she was eventually shifted to the medical college.
- On the way to the medical college, Miriam asked the ambulance to take a detour to meet her family, as the family was uncertain about Miriam's life.
- In the medical college, as per the norms, investigations should be conducted 24 hours seven days a week and as the laboratory was closed, crucial time was lost in getting the investigation done outside in a private clinic.

**Samia Afrin**, coordinator of the Women's Health and Rights Advocacy Partnership (WHRAP) at Naripokkho recounts, *'If there was any accountability within the hospital, the service providers would have taken responsibility being responsive to Miriam's condition, where her death could have been prevented. There is a strong link between accountability and building a public movement. Naripokkho recognised this and we started working around it. Our movement and activism was based on questions raised about service accountability or political accountability that can prevent the needless death of women'*

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## B. Naripokkho: Bringing Women's Health Rights Centre Stage

Naripokkho, which means pro-women or taking women's side in Bengali, is a national women's organisation founded in Bangladesh 1983. Bangladesh became an independent nation in 1971. Since then, it has been struggling with challenges of nation building including political instability, poverty and uneven social development. Health and education services through the public sector have remained weak. However, large NGOs emerged soon after independence to fill this void in public services. Naripokkho holds the unique distinction of being the first non-political women's organisation in the country and was the first NGO to start working for women's rights. It was born as a result of a three days' workshop organised by Asian Cultural Forum on Women and Development (ACFOD) in 1983. 33 Bangladeshi development workers, all women, concerned about social change and development, came together to share their experiences. They talked about various organisational initiatives as well as stories of working with the beneficiaries. The discussion soon veered towards the personal as they spoke about struggles for their own rights and freedoms as women and the challenges and violence faced within families. Eventually what emerged was the birth of Naripokkho, an organisation that has focused on issues related to women rights.

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*"Women have systematically been underrepresented at every level in Bangladesh. This marginalisation has weakened women's capacity to promote their interest and defend their rights in a male dominated society. Naripokkho was the first to recognise this marginalization early on."*

U.M. Habibun Nessa, Naripokkho

Naripokkho since then is sustained by its members (who now number 110). It works through partnerships and networks and is engaged in all the 64 districts in Bangladesh. One of its major partnerships is with Doorbar, a women's network that is primarily focused on political empowerment and preventing violence against women.

**Mahmuda Begum** from Doorbar shares *"In our alliance, we have women from diverse background Some of them are uneducated and never been to school, some have finished primary schooling, some their Masters; but then the skills of each women is the same, maybe a woman who has completed her Masters would hesitate to go to police station but women who are uneducated will not hesitate to go to the police station and stand to fight for her right or other women's rights, as it is also a question of her survival. There is a synergy amongst the Doorbar members, though our identities are different, the greatest achievement of Naripokkho is bringing women from different sections and creating a synergy to stand up together for other women's rights."*

At the same time, Naripokkho has supported, built and strengthened 37 Community Based Organisations (CBO) in 29 districts. The focus of these CBOs is on reproductive health, rights, and violence against women and they work directly with women in the community. Their struggle is not only against the health system but is also directed towards their own community that has patriarchal beliefs that a woman's purpose in life is to work, reproduce and take care of the men. As **Shahabuddin Panna** from *Najrul Smriti Sangsad, Amtalli* says “Women make up half of the population. It is important that they are brought out of the homes and given independence. As a man, I feel strongly about it. In our society, men have always treated women as second grade citizens. Reproductive health and rights are never discussed. It is important that we bring this out in the open and speak about it. Our partnership with Naripokkho is not a project but a movement. For us, it was important that we reached out to the most poor and the most marginalised women from their own spheres (family, community and village) and talk to them about their health entitlements and empower them”.

Naripokkho's approach to women's rights has consciously avoided the use of the term 'empowerment' (except in specific contexts), conceptualising the larger problem in terms of women's human rights, citizenship rights, accountability, position and condition.<sup>1</sup> *Samia Afrin* explains this difference in approach saying that most policy planners, academicians, and even NGOs believe that economic development of women will lead to their empowerment, whereas the ground reality is very different. Evidence from the field indicates that there is a need to address and empower women to claim their rights and entitlements along with economic empowerment. One does not automatically lead to the other; both of them have to be simultaneous.

Naripokkho's work over the last three decades has included different dimensions of women's rights. Some of the important milestones in its work are as follows:

- In the late 1980s, Naripokkho raised issues related to the government's target oriented population control initiatives and the abuse of sterilisation. It pleaded for safe delivery services, safe contraception, reproductive rights and freedom. In 1989, it highlighted the abuse of the Norplant (a contraceptive implant) programme. Doctors were reported to be refusing to remove the implant when women complained of side effects!
- In 1993-94, Naripokkho decided to work on reproductive rights. The approach was reflected in its slogan *Shoreer amaar, shiddhanto amaar* (My body, my decision). The move drew widespread criticism and resistance from many including several civil society organisations. However, Naripokkho continued its work.
- A landmark judgment on a petition filed by Naripokkho to challenge the eviction of brothels in Tanbazaar and Nimtali in Narayanganj proved to be an important turning point. The high court declared the eviction illegal and recognised sex work as an occupation. This win created awareness about the powerful role of communities in holding the government responsible for the safety and protection of women and their rights.

<sup>1</sup> IDS WORKING PAPER, Volume 2011 Number 368, National Discourses on Women's Empowerment in Bangladesh: Continuities and Change: Sohela Nazneen, Naomi Hossain and Maheen Sultan July 2011

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- During 1995-97, Naripokkho conducted a study on violence against women. The findings were alarming. Sixty percent of the women interviewed across all classes had experienced conjugal violence. In addition, 63 percent of violence related injuries requiring hospitalisation had occurred within the home. This further strengthened its resolve to work on domestic violence.
- In 1996, Naripokkho also took up the issue of accountability of health service providers. It monitored government's responses aligned to its commitment to the Programme of Action of the International Conference on Population and Development (ICPD). Naripokkho took the initiative of activating the *Upazilla* Health Advisory Committee set up by the government to monitor and improve health service at the local level. The Committee, comprising public representatives and Government officials, soon started producing encouraging results.

*“The idea that a woman really struggles to access health services motivated Naripokkho to look into accountability to strengthen citizenship. One of our honorary members, Dr. Yasmin Ali Haque, gave the idea of making health services pro-women and gender friendly.”*

U.M. Habibun Nessa, Naripokkho

*“There is a strong link between accountability and movements and this was recognised by Naripokkho. Our movements and activism are in response to questions raised about service accountability or political accountability. However, in Bangladesh, it is definitely challenging. Also, it was important for us to look at citizens' involvement at two levels. This included bringing them together at the community level to hold service providers accountable for the services they do not receive despite being entitled to them. It was also about holding institutions responsible for improving quality of care and ensuring safety and protection of all those vulnerable women who have faced violence and abuse and are not able to access sensitive care and services due to non availability, apathy or insensitivity of service providers.”*

Samia Afrin, Naripokkho

Traditionally health service users are not asked to evaluate health services, nor do health rights of women prominently figure in political platforms or debates. Realising this, it has been an ongoing process for Naripokkho to lobby with government and international bilateral donors (who play an important role in supporting government) to create conducive environment and create a safe space for women who require to visit the local as well district hospitals. In the late 1990s, Naripokkho held a series of workshops to address women's health problems and create women friendly hospitals. Subsequently, after three years of rigorous planning, developing protocols with operational guidelines and checklist worked to establish a client friendly and gender sensitive hospital. The protocol was the first of its kind in Bangladesh and included the concept of women friendly care that included:

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- Women's need for respect, privacy and confidentiality
- The need for trained health care providers to identify and provide treatment and support to woman survivors of violence
- Create safe spaces for women to rest and breast-feed her child within the hospital.
- Committees comprising of communities who could guide the hospital in ensuring that no woman is turned away due to lack of services or insensitive service providers.
- An accreditation checklist within the framework of public health standards.

United Nations Children's Fund (UNICEF) in three district hospitals financially supported the pilot project in the late nineties, and the government later adopted it and rolled it out in 23 districts. Currently UNICEF support has ended and the government plans to roll out this initiative in all the districts of Bangladesh. Naripokkho is an integral part of the discussion with government to lead and support this initiative in all the districts of Bangladesh.

The increasing engagement of Naripokkho in hospital-based care helped it to understand the relative neglect of health services and apathy towards the needs of the poor. It reevaluated its work. Clearly, mobilising women, creating awareness and linking communities with services was not enough. Accountability emerged as a top priority. Moreover, its members strongly felt the need for direct involvement of communities as a means of improving health services.

These insights were concretised into formal initiatives, and today Naripokkho with its partners and networks is involved in monitoring and collecting operational data from a large number of health facilities that includes:

- Obstetrics department of Sher e Bangla Medical College in Barisal
- Zilla Sadar Hospitals of Patuakhali and Borguna districts
- Patuakhali and Borguna Mother and Child Health Care Centres
- Eleven Upazilla Health Complexes
- Sixty four Union Health and Family Welfare Centres

Naripokkho aims to improve accountability of maternal health services through a multipronged strategy where:

- Women are organised, are aware of their entitlement and are able to demand and negotiate better healthcare from healthcare workers.
- Third party monitoring of health facilities to identify gaps in quality of care.
- Engagement with the hospital management committees (which include people's representatives, NGO representation, media personnel and officers of the health department) to not only improve the quality of care given by hospitals but also create a sense of accountability among the healthcare workers.

The WHRAP initiative provided Naripokkho a platform to implement this approach.

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# Chapter 2

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## **Strengthening Accountability of Health Systems**



## A. Women Demand their Health Rights: The Nari Dal Experience

*Duli Rani, a member of the women's group Nari Dal, belongs to Uttar Itbariya village of Aila Patakata Union of Barguna district. She took her daughter Anjana to the Second meeting at Nari Dal on 17th November 2011. Since Anjana was pregnant, the group discussion for the day focused on services related to pregnancy, risks during pregnancy, services available at the Family Welfare Centre and issues related to women's health rights. Duli Rani listened to the discussion with interest and soon took Anjana to the Aila Patakata Union Health and Family Welfare Centre. The Family Welfare Volunteer (FWV) Nasima Begum asked for a sum of 100 taka (about 1.33 USD) from Duli Rani to make Anjana's Antenatal Card. Duli Rani did not have any money and requested Nasima Begum for the card, but she refused. Disappointed Duli Rani returned home and discussed her experience with other members of her group. The members of her group were upset and the following week, four members of her group accompanied Duli Rani and Anjana to the Health and Family Welfare Centre. Nasima Begum repeated her demand for 100 taka. The women Protested, claiming that these services are provided free of charge. They mentioned that if the card was not provided to Anjana, they would complain to senior officials including the Chairman of the Union Parishad (local government unit). Nasima Begum was now compelled to provide Anjana with the requisite checkup and gave her the Antenatal Card.*

The women of Uttar Itbariya village were organised and trained by the local women's NGO Jagonari who are members of the Women's Health and Rights Partnership (WHRAP) convened by Naripokkho. Since 2003 Naripokkho has been working with 16 local women's NGOs in 14 Upzillas of the five districts of Barisal, Barguna, Patuakhali, Jhalkathi and Pirozpur through WHRAP. Today there are 32 women's groups or Nari Dals with 640 active members. Each member is expected to work with at least five women among her friends and neighbours. The primary aim of this social mobilisation initiative is to bring women from marginalised communities together and enable them to advocate for their rights. It is also an attempt to create a movement to improve quality of health care.

Naripokkho along with 16 of its NGO partners focus on the poorest of the poor and the most marginalised women and selected those with communication skills. Many of these young women (married and unmarried) had availed services in the past but were dissatisfied with the health care system. They were reluctant to access health services from community hospitals or Upazilla Health Complex (Sub District Hospital). Through the WHRAP programme, Naripokkho provided training and other support to workers of the partner NGOs who in turn train the women leaders of the Nari Dals and conducted regular meetings. In these meetings, various concerns such as the condition of health centres including availability of free medicines, quality of health care, danger signs related to women's health and women's rights were discussed.

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The emphasis was on enhancing their knowledge and skills on rights, entitlements and obligation of the government to protect their rights, availability of free services by the government health facilities and improved quality of care. Strengthening Leadership skills of women are strengthened. Women were encouraged to demand their entitlements from the healthcare service providers. By participating in these meetings, women of the village have now become active seekers of health services and see these as their right.

*“It angers me that till date I have been paying for services which should have been free. Now whenever I visit the health centre, I demand for services instead of begging for them. This is something I have learnt from the Nari Dal meetings,”*

**18-year-old Putul, Nari Dal member.**

*“I used to pay 50 Bangladeshi taka every time for the medical services that I should have got free of cost. I realised that I was being taken for a ride and am angry about it. The Government health services are free and the healthcare providers receive salaries from the government to provide us free services. When I mentioned this to my husband, he was equally angry. Now, I take women from my village to the hospital and the moment they demand money, I stand up for my rights. I demand to know why they are asking for money. They immediately provide free service.”*

**28 year old Anjana Rai, Nari Dal member**

## CHALLENGES

Initially, most of the Nari Dal members faced considerable opposition within their families and communities. As 28 year old Anjana Rani shared, “My husband used to be very irritated with my involvement in the Nari Dal. Even in the village, everyone would ask me why I was involved in it. I also did not know why I was attracted to it.” Gradually, these responses changed as people began to see the benefits of being involved in the Nari Dal. However, women’s own domestic workload prevents them from becoming very active in the Nari Dal.

While access to many services improved, access to institutional delivery services has remained problematic. As 37 year old Farzana Islam shared, “I had to give birth to all my three children at home. For the first one, the nurse came home and delivered it. However, with the second and the third one, the doctor in the Upazilla Health Complex told to me - You do not have any problem. go home and deliver. So, though I was scared and wanted the child to be born in the health centre, I was forced to have it at home.” Samia Afrin, Naripokkho, elaborated, “It is frustrating that government listens to donors. Here, 80-85% of deliveries are conducted at home by Traditional Birth Attendant (TBAs). Yet, TBAs have been banned in Bangladesh and so, there is no training of these TBAs as well. Donors are pushing for institutional delivery but the health institutions are not equipped to handle institutional delivery. Shahabuddin Panna, NGO partner- Najrul Smriti Sangsad, also confirmed this. “It is a reality that women are turned away and asked to deliver at home as health institutions are ill

**Women were encouraged to demand their entitlements from the healthcare service providers. By participating in these meetings, women of the village have now become active seekers of health services and see these as their right.**

The women members of the Nari Dal are no longer passive seekers of services who the local health provider can treat as they like. Each month the members from 27 Nari Dals conduct monitoring visits to their local Union Health and Family Welfare Centres. They have also been able to push the inactive antenatal care services to function. In Laukathi Union, the women members were able to ensure that 42 women received antenatal services through their meetings and representations with the functionaries.

*“At the Kalmegha Union Health Centre, the junior staffs were unwilling to give medicines and misbehaved with women from the community. Then, all the Nari Dal members went and started shouting slogans. They stopped all the work at the centre. The issue became so big that higher officers were forced to intervene and transfer the errant junior staff. What started as a small initiative has now become big. Women from the community have really become involved and it is slowly turning into a movement.”*

Mirza Shahidul Islam Khaled, (NGO Partner)

The leadership displayed by the women marks a significant change in a society which is extremely patriarchal.

*“I am unmarried and sometimes the health providers question me - you are not married so what do you know? But I am strong and a good speaker and I fight with the health providers. So, automatically, married women ask for me when they have any problem with service provision. I know that the hospital should give us 26 types of medicines for various illnesses and it should be available in the family welfare centre. We fight when the providers say we do not have these medicines. Community members like the fact that there is somebody to fight for them. Many of them are amused. But now, everyone comes to us if they face any problem in the health centres.”*

#### **25 year old Shaheenur Akhtar, Nari Dal member**

*Today these women are organised and are willing to face up to the most recalcitrant health workers demanding their rights as the story below demonstrates.*

*Diuli is a village in the Subidkhali union of Mirzaganj Upazilla. Most of the residents of Diuli are very poor. The local Union Health and Family Welfare Centre has been lying vacant for a long time and women from Diuli have been deprived of essential maternal health services for a long time when the WHRAP partner Shuktara Mahila Sanstha started a Nari Dal in the village. In March 2013, Amina Begum a resident of Diuli went to the Union Health and Family Welfare Centre. The Sub Assistant Community Medical Officer (SACMO) Ahmad Jabbar asked for 50 taka for the treatment and refused to give the medicines unless he was paid this amount. Amina Begum returned to her village and consulted her Nari Dal leader Shahida Begum. Having heard Amina Begum out, Shahida Begum along with two other members Baby Begum and Shahinur Begum went along with Amina Begum back to the Union Healths and Family Welfare Centre. They confronted the SACMO about his asking for money and said that they would lodge a complaint against him with the standing committee on education health and family welfare of the Union Parishad. At this the SACMO said that Amina Begum had misunderstood him and that he had never asked for any payment, and gave her the required medicines.*

*The Nari Dal women are one face of the women's movement that Naripokkho has been able to facilitate across one of the poorest regions in the world.*

*"Being a member of Nari Dal has really helped me in understanding that health services have been established for us. So, our primary responsibility is to motivate women to avail services. If they do not get it, then we at Nari Dal stand up to demand for the services. Now all the pregnant women avail services at the family welfare centre and the service providers too are willing and recognise us. We have learnt everything about pregnancy and the services that we will get and this is what we teach the women in our villages."*

**Farzana Islam, Nari Dal member**

*"The Nari Dals that we have established are ready to take forward issues and movements. These Dals have inspired the community to talk about issues related to women, not only about their health but also their rights. We have gone beyond monitoring health services. We have also thought of violence against women as a health issue. So, the Nari Dals discuss about it, though they do not directly deal with it. Both the Nari Dals are strong, and we selected women from the most marginalised, economically backward sections including single women. We also have men in our group."*

Mirza Shahidul Islam Khaled, partner NGO

## B. Improving the Quality of Maternal Health Services by Local Monitoring: An Initiative of Local NGOs

*The generator at Patuakhali Mother and Child Welfare Centre was out of order. The partner organisation discovered that the generator was key problem because the expectant and recently delivered mothers who come to the health centre suffered from intense heat. Without a generator means delayed caesarean operations that leads to additional complications for women. This problem was discussed at the coordination committee meeting of district NGOs. It was brought up with the Associate Director of Family Planning Dr. Jasimuddin Mukul and Uazilla Family Planning Working Officer Piyara Begum. After learning about the malfunctioning generator Dr. Jasimuddin Mukul visited the Mother and Child Welfare Centre and had discussions with patients and service providers at the hospital to understand the problem. As a result of these discussions, Dr Mukul immediately sanctioned the purchase of a new generator with funds from the Family Planning maintenance budget to ensure that caesarean operations took place without any problems.*

In addition the 16 partners of WHRAP regularly monitor the services at 16 health centres. They visit the appointed health centres twice a week, spending between 6 to 7 hours monitoring the administrative functioning of health centres. Among the things they monitor are the cleanliness of the facility, the attendance of providers and their behaviour towards women patients. They share their observations in the meetings

with the hospital management committee as well as at the Zilla and Upazilla NGO coordination committee meetings. These efforts have now led to the improvement in the quality of services delivered through these hospitals, such as:

- **Uninterrupted power supply:** The generators at Dashmina and Mirzagunj health centres were not working, due to the disruptions in electricity supply. WHRAP partner organisations identified this problem through their regular monitoring visits and raised the issue with the hospital administrative staff. On 20 March 2012 and 15 July 2012, the hospital management committee of Dashmina and Mirzagunj hospitals respectively discussed the issue and the generators were repaired with funds from the hospital maintenance budget.
- **Cleanliness:** The Pathorghata Upazilla hospital was untidy due to the lack of janitors. After the discussions with the Mayor of Pathorghata municipality, who is also a member of the Pathorghata Upazilla hospital, two persons were appointed from April 2012, out of the municipal budget. The issue of inadequate cleanliness was raised by partner organisations with many hospital management committees and presently six hospitals (Patuakhali Mother and Child Welfare Centre, Mirzagunj, Dashmina, Kathali and Bamna sub-district Hospital and Barguna District Sadar Hospital) are sanitized twice a day.
- **Arrangements for a new ambulance:** Anwesh Social Service Association, the partner organisation of Dashmina Upazilla of Patuakhali district, is regularly monitoring the Upazilla Health Complex. During their monitoring visits they observed that the ambulance was non-functional for over a year, seriously affecting the transfer of patients who needed to be referred to another hospital, especially women with obstetric complications. Tom-toms, the local transportation and buses are available only till 4 pm. Therefore, without organised transportation, many patients' families did not want to travel beyond that time, leading to additional complications for the mother and newborn. This issue was raised repeatedly by Anwesh functionaries with the hospital administration, Upazilla Family Planning Officer (UHFPO) Dr. Abul Khayer and Upazilla chairman Abdul Aziz. Realising the gravity of the concern, the Upazilla Chairman informed the Member of Parliament Golam Moula Ronny, who promised to raise it with the Minister of Health A. F. M. Ruhul Haque when he came to Dhaka. The Upazilla Chairman went to Dhaka and met the Minister of Health. A new ambulance was procured and handed over to the Dashmina Upazilla Health Complex on 12 January 2012. All the officials commended Anwesh's efforts through their monitoring visit.
- **Ending illegal payments:** Health care providers of Dashmina Upazilla hospital and Patuakhali Mother and Child Welfare Centre used to illegally charge 20 to 50 Taka from patients. The local partner NGO noted this during their monitoring visits. The issue was raised with the Upazilla hospital management committee and the Upazilla Chairman. As of Dec 2012, these illegal charges have stopped in Dashmina. A similar situation was noticed in Bamna Upazilla hospital where health care providers used to charge 50 to 100 Taka from patients. The issue was raised in the hospital management committee and the practice has stopped from July 2012. Similarly, it was noted that health care workers at Kaukhali Upazilla Health Complex charged patients for services. This

was discussed with the officials and later a notice board was put up in the hospital asking the patients not to make any payment without a receipt.

- **Notice boards regarding consultation hours:** It was noted that Medical Representatives (MR) at Patharghata Upazilla hospital would often enter doctors' chambers during consulting hours. This would distract the doctors from examining the patients and women would hesitate in sharing their health problems openly. At first the MRs were requested to abstain from visiting the hospital during the consultaion hours but they did not listen. This concern was taken up with the Upazilla Health and Family Welfare Officer but to no avail. The issue was then raised with the hospital management committee and in October 2011 a decision, forbidding MR visits during consulting hours was put up on the notice board. Today 12 of the 16 hospitals are regularly monitored have put up similar notice boards.
- **Increasing rooms for patients:** In Barishal's Sher-I-Bangla Medical College, insufficient beds for maternity patients meant that many patients had to lie on mattresses on the floors and corridors. This issue was raised with the director of the hospital, the president of the hospital's management committee and the mayor of Barisal Municipal Corporation. As a result of these discussions, one room was added to the maternity wing of the hospital. Similarly, an additional room was made available for diarrhea patients at the Bamna Upzilla Health complex.

## CHALLENGES

- *Entering public health facilities and monitoring their services was not easy. The local organisations were initially treated with suspicion and even barred from entering the facilities. District health officials would always ask if the NGOs had obtained permission from higher authorities. Lack of such permission meant that they could be easily turned away. Higher authorities were also usually reluctant to discuss health care provision issues with the NGOs. In such a context, community members were even more disadvantaged.*
- *The NGOs gradually took on a mediatory role, helping communities and service providers to dialogue. Thus, even as communities raised issues and challenged the service providers, NGOs helped the district health officials in improving the situation. However, past experiences and the usually adversarial relationship between NGOs and health administration were difficult to overcome fully.*
- *Hospital authorities also procrastinated and often denied information on services. "Even now, we receive mixed signals on the kind of services that should be provided to us. So even if you complain, sometimes the higher authorities say that these services are not available," said Anjana Rai, Nari Dal member.*
- *As mentioned earlier, ensuring regular hospital committee meetings was also challenging. Disputes between members were common. Also, the councilors often spent most of their time in Dhaka. Further, relationship building with state and district authorities was hampered by frequent transfers of key officials.*

The monitoring of hospitals and health centres was done using standardised protocols developed by Naripokko with the Government in 2005. Naripokkho had used these



protocols earlier in a UNICEF funded project implemented in collaboration with the Directorate of Health, which covered 21 district hospitals, and 4 Upazilla Health Complexes.

## C. Institutionalising Accountability: Activating Hospital Management Committees

The Bamna Upazilla Hospital Management Committee was not being constituted for a long time. Functionaries of Naripokko partner Sankalp Trust repeatedly contacted the Upazilla Health and Family Welfare Officer and then got in touch with the local MP and the Chairman of the Upazilla as well. Naripokkho officials met with the MP in Dhaka and finally a meeting was organised in the Upazilla Health Complex compound on the 18<sup>th</sup> December, 2012.

The MP Gholam Sabur Tulu and other local officials were present at this meeting. At the very outset Mirza Khaled, director of Sankalp Trust requested the honourable MP to constitute the Hospital Management Committee highlighting its importance. A decision to form the committee was taken at this meeting and it has been meeting regularly ever since.

Hospital Management Committees (HMC) is mandated for all public hospitals in Bangladesh as a means to improve quality of services as well as resolve local problems. These committees are supposed to convene once every month; however, for all practical purposes these Committees are often non-functional. According to the rules, these management committees are chaired by the local Member of Parliament and include twenty-one members drawn from different stakeholder groups including elected local government officials as well as health department officials and hospital employees. Civil society members include an NGO representative, the Chairperson of the local press club and a well-known citizen. Activating these committees has been an essential component of the accountability strengthening measures adopted by Naripokkho. The activation of these committees has been able to provide additional impetus to the monitoring exercise. However, even without local monitoring these committees provide a platform for discussing local problems and identifying local solutions. These committees provide an opportunity to the local NGOs to place the problems faced by women. Local elected representatives also raise issues faced by the people and often provide resources for solving problems locally. Problems that cannot be resolved locally are referred to the health ministry. Many of the problems that are raised locally are associated with the lack of accountability of hospital staff.

Some of the issues that have been resolved through these committees are as follows:

- Earlier, many doctors conducted their own practice during hospital hours. Many doctors used to conduct their practice from clinics at their residents. They used

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**Committees provide an opportunity to the local NGOs to place the problems faced by women. Local elected representatives also raise issues faced by the people and often provide resources for solving problems locally. Problems that cannot be resolved locally are referred to the health ministry. Many of the problems that are raised locally are associated with the lack of accountability of hospital staff.**

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to charge patients 50 to 100 Taka as fees for their services. This trend of doctors carrying out private practice was discussed at the Hospital Management Committee meeting and now doctors conduct private practice only after hospital hours.

- Earlier, many departments of the hospital would charge 5 or 10 Taka from patients. This illegal practice has been stopped.
- The food provided to patients was of poor quality. After many negotiations and call for improving the quality of food at hospital management committee meeting the patients are now given better quality meals.

Activating these committees has not been easy. It has required sustained efforts by Naripokkho officials as well as members of its partner organisations. Some of these efforts include:

- Regularly meet with committee members, particularly the local Member of Parliament. In many cases the MPs live in Dhaka and even when they visit their constituency, they are mostly busy with 'political' activities, and so meeting with them is not easy.
- According to rules in the absence of the Chairperson, the Upazilla Chairman (at the Upazilla level) or the District Administrator (at the Zilla level) can preside over the meetings of the HMC, however they are also not very keen and need to be met and convinced to hold the meetings regularly.
- Regular communication and follow up with all the members of the HMC, to ensure that they are present at the meetings and address the problems that have been identified.
- Convince the MPs either to raise the referred issues in the Parliament or to take them up with the health ministry officials.
- Members of Naripokkho are also lobbying with the members of the parliamentary standing committee on health in order to regularise committee meetings through statutory means.

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**After many negotiations and call for improving the quality of food at hospital management committee meeting the patients are now given better quality meals.**

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## CHALLENGES

- In many cases, the members of the HMC are not aware that they are members of it.
- Officers of the health department feel that these meetings are arranged to harass them so they don't like to set up these meetings or attend them most of the time.
- Personal and political relations between local politicians sometimes influence their attendance and participation in these meetings
- These committees do not have any formal authority and also lack any separate funds of their own. This seriously hampers the effectiveness of these committees.



# Chapter 3

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## Conclusion



The stories and incidents presented in this case study show three inter-related approaches to strengthening community involvement for governance and accountability that aim at providing better health services for women. These approaches build upon the close connection that local NGOs have with their communities and the expansion of notional spaces that are provided within existing governance structures for NGOs to intervene.

Naripokkho is a national organisation but it leverages its relationship with grassroots organisations to increase their effectiveness and at the same time uses its position in the national capital of Dhaka to build relations with the Members of Parliament who have great influence within their constituencies. This approach also attempts to bring the government closer to the poor women by actively engaging with the directly elected local representatives like the Union Parishad Chairman or Mayor of the city municipal corporation.

While cultivating influence and relationships with local and national political entities provides the project with advantage, its political edge lies in the direct capacity building and entitlement awareness of local women through the Nari Dal. These groups have started becoming platforms for mobilisation and collective demands for transparency, accountability and better governance. This process empowers communities, strengthens citizenship and holds the promise for deepening democratic governance.

The WHRAP initiative has made an important beginning by strengthening capacities of women to hold those who plan, finance and deliver services accountable. The greatest contribution of Naripokkho has been in helping and nurturing citizenship at the grassroots, especially for the poor and marginalised who are usually excluded from the democratic decision making process. It has attempted to create awareness about government's responsibility towards citizens as well as encourage citizens to act as right bearers, particularly women who have often been isolated and discriminated.

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**The greatest contribution of Naripokkho has been in helping and nurturing citizenship at the grassroots, especially for the poor and marginalised who are usually excluded from the democratic decision making process.**

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# Annexures

## ANNEXURE 1

### Bangladesh: Profile of Women's Health

Bangladesh is the eighth most populous and most densely populated countries in the world. It is a predominantly rural country with nearly 75% of the population living in rural areas. It is also a very poor country with over 50% of the rural population being landless and a third earning less than a dollar per day.

Women account for about 50% of the total population. Like many other South Asian nations, women in Bangladesh face gender discrimination and apathy, domestic violence and other manifestations of a predominantly patriarchal society.

#### FACT FILE

<b>Official name:</b>	People's Republic of Bangladesh
<b>Total Population:</b>	144,043,697
<b>Shares International Borders with:</b>	India and Myanmar
<b>Capital:</b>	Dhaka
<b>Key Religions Practiced:</b>	Islam (majority), Hinduism
<b>Form of Government:</b>	Parliamentary Democracy; has experienced military coup
<b>Administrative Structure:</b>	Seven administrative divisions, each further divided into districts ( <i>Zilla</i> ) and then sub districts ( <i>Upazilla</i> ). The Upzilla are further divided into Thana or Unions.
<b>Local government:</b>	Direct elections are held Union Parishad and Wards and these bodies are managed by elected representatives.

High fertility and high maternal mortality rates have been areas of critical concern in the past. However, over the last few decades there have been major changes in these statistics. The total fertility rate was 6.3 in 1975 but is now 2.3 while the Maternal Mortality Ratio has reduced from 574 maternal deaths for every 100,000 live births in 1990 to 194 deaths for every 100,000 live births in 2010, making it one of the few countries that will achieve the Millennium Development Goals (MDG) 5. Service delivery figures continue to be poor and according to the Bangladesh Demographic and Health Survey of 2011, only 26 percent of women who had a child in the last three years received the recommended four or more antenatal care (ANC) visits. Only 29 percent of recent births were conducted in a health care facility. The poorest women were the least likely to receive care, and these women continued to give birth with minimal support from the health care system. According to the Bangladesh Maternal Mortality Survey 2010,

a vast majority of deliveries continue to take place at home, supervised by trained birth attendants (TBAs) or relatives.

The Bangladesh National Maternal Health Strategy is the official programmatic approach to improving maternal health services. Under this strategy, the Government aims to bring services to the doorstep through a network of Community Clinics, one for every 6000 population. Over 12,500 such Community Clinics are currently operational each with one Community Health Care Provider. Public sector health facilities include 3,275 Union Health and Family Welfare Centres, 391 Upazila (sub-district) Health Complexes and 64 district hospitals. The Government has also started Emergency Obstetric Care services in 143 Upazillas with plans to roll it out in all Upazillas subsequently. The Union Health and Family Welfare Centres provide essential maternal and child health care.

Even though there are efforts to provide health services for all and women have health rights, women themselves are not always aware of their own entitlements. In many cases, the health centres are not provided with appropriately trained health workers or equipment. High cost of care is also a barrier for many people more so with women. In the case of women their husbands, parents or their in-laws direct their health needs. Women's access to reproductive health rights are also mediated by women's low social status, harmful traditional beliefs and practices as well overall poverty and lack of communication .

## ANNEXURE 2

### List of Partner NGOs and the Work Area

1. Sankalpo Trust , Patharghata Upazilla
2. Nazrul Smriti Sangsad (NSS) , Amtoli Upazilla
3. Jagonari, Borguna Sadar
4. Community Based Development Project (CBDP), Borguna Sadar
5. Integrated Social Welfare Association (ISWA), Betagi Upazilla
6. Earth- Samajik Shikha Sanskritik Unayan Sansthan , Bamna Upazilla
7. Shaplaphul Social Development Organisation (SSDO), Patuakhali Sadar
8. Adarsha Mahila Sansthan, Patuakhali Sadar
9. Anwasha Samaj Seba Sangha, Dashmina Upazilla
10. Patuakhali Development Organisation (PSO), Bauphal Upazilla
11. Shuktara Mahila Sansthan, Mirjaganj
12. Barisal Mahila Kalyan Sansthan (BMKS), Barisal Sadar Upazilla
13. Social Upliftment Voluntary Organisation (SUVO), Banaripara Upazilla
14. Children and Youth Development Organisation (CYDO), Rajapur Upazilla
15. Development of Economic and Social Centre (DESC), Kathalia Upazilla
16. Dr Dhiren Sikdar Foundation, Kaukhali Upazilla





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