Agenda Setting on Community Health in Bangladesh

Thesis Submitted By

Md. Golam Rabbani
June, 2010

Master in Public Policy and Governance Program
Department of General and Continuing Education
North South University, Bangladesh

Dedicated

To

My beloved Parents

ABSTRACT

Health policy making is not a simple function. Like as other policy process, policy making in health policy also has the effect of politics on idea generation, formulation and implementation of public policy. This interplay of different actors in policy process is well known as politics in public policy. The case of health policy formulation in Bangladesh is not separate from the universal theory of policy process. Till today, health situation of Bangladesh is not satisfactory in term of 'equity and justice'. Due to lack of national priority setting, shift of visions and direction with the change of regime, policy makers and field level bureaucrats lost their ownership which ultimately hampers the policy implementation. In the literature of policy ownership source of ideas/visions is treated as one of the major indicator to measure the ownership of policy. In public policy process 'agenda setting' is a stage where owner of ideas/vision and promoter of the ideas take different strategy to capture the attention of the policy makers. In public policy making 'ownership' can be measured with participation of different actors in policy process. In this connection role of different actors were investigated in this study. To attain the objective of the study, a mixed method approach was chosen where qualitative method was dominant and it was supplemented by quantitative method. As well as Johon Kindon's theory of 'Garbage Can Model'(Basically three streams) and Howlett and Ramesh' s Sub-System Approach were used as theoretical guidelines.

In this we found that evidence created by the state actors and non-state actors played vital role to highlight the community health issues for policy decision making. Evidence about vulnerable situation of maternal and child health of rural community, population problem and family planning in rural Bangladesh, absenteeism of the health professionals in rural remote areas, imbalance distribution of health professionals, problems to ensure the women friendly health services and alarming situation of HIV/AIDS knowledge in the community levels were the main factors to increase the significance of the rural community health issues in Bangladesh. In evidence creation, donors played more dominate role by setting study indicators and methodology. Also, NGOs/CSOs played significant role in evidence and policy demand creation. NGOs make sure the of participation top level bureaucrats, elite people in the health sectors who have good connection with the policy makers and leaders of media community. To highlight the community health issues people from medical professional body, top management of NGOs and people from donor community formulated different advocacy groups.

Internationals policy and national policy coherence, positive attitude of donor, pressure from the NGOs, national and international success model of community health initiatives were the dominant factors for selecting the set-up of community clinics in the village level. In the time of advocacy advocates highlighted the government commitment to the national and international community (like MDG, Health for all etc). In the time of success examples creation, donors were at important role by providing financial and non-financial resources. The donors helped the partners in capacity building and in mapping of successes examples.

In case of political support, as a political party AL had committed to set up the community level and they highlighted these issues in the election manifesto of 2009. Also, top level policy makers like the Prime Minister and Health Minister were enthusiastic to promote the community health issues and they publicly announced their commitment to set up the community clinic at village level.

It can be said that proper evidence for highlighting the problem, stakeholders' support to the solutions and strong political support highlighted the community health issues as candidates for government actions. In evidence creation and advocacy, NGOs were vocal and NGOs were backed by the donors. Top level bureaucrats played their part with the help of consultants who were generally recommended by the donors. Finally, recognition of ruling political party was very much positive to the issues due to their commitment in the election manifesto.

CONTENT

Page No.

LIST OF TABLES

LIST OF FIGURES

LIST OF ANNEX

LIST OF ABBREVIATIONS & ACCRONYMS

Abbreviations	Elaborations
AMC	Alternative Medical Care
GOB	Government of Bangladesh
HPSS	Health and Population Sector Strategy
ICESCR	International Covenant on Economic, Social and Cultural Rights
UFPOs	*Upazila* Family Planning officials
ACPR	Associates for Community and Population Research
AL	Awami League
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
BDHS	Bangladesh Demographic and Health Survey
BMA	Bangladesh Medical Association
BRAC	Bangladesh Rural Advancement Committee
BWH	Bangladesh Health Watch
CHW	Community Health Workers
DAB	Doctors Association of Bangladesh
ESP	Essential Service Package
FP	Family Planning
FWAs	Family Welfare Assistants
FWVs	Family Welfare Visitors
GCM	Garbage Can Model
GK	Ganoshastho Kendro
HCPs	Healthcare Providers
HNP	Health ,Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Program
HPSP	Health and Population Sector Program
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
INGOs	International NGOs
kabiraj	Traditional healers
MA	Medical Assistant
MBBS	Bachelor of Medicine and Bachelor of Surgery

MICS	Multi-Indicator Cluster Survey
MOHFW	Ministry of Health and Family Welfare
NGO	Non government organization
NHP	National Health Policy
NIPORT	National Institute of Population Research and Training
NSDP	NGO Service Delivery
Palli Chikitshak	Local village doctor without any professional degree)
PRSP	Poverty Reduction Strategy Paper
PSO	Program Support Office
RMP	Rural Medical Practitioner
Shasthya Kormis	Health Workers
TFR	total fertility rate
Thana	Sub-district
TK.	Taka
UDHR	Universal Declaration of Human Rights
UHFWC	union health & family welfare center
WFHI	Women Friendly Health Initiatives

ACKNOWLEDGEMENT

I would like to take this opportunity to express my acknowledgement to several persons and institution whose support immensely contribute to make the study success. First and foremost, I wish to convey my heartfelt gratitude to my supervisor, Dr. Mobasser Monem, for his tremendous help and encouragement with my thesis. I am highly indebted to him for his invaluable advice and intellectual guidance throughout my thesis writing. Without his support my thesis would not be able to see the light.

I would like to convey cordial thank to Professor Dr. Salahuddin M. Aminuzzaman, Dr. Ishtiaq Jamil and Dr. Pranab Kumar Panday, Dr. Sk. Tawfique M. Haque, to enrich me with their profound advices, which helped me to refine and accomplish the daunting task.

I am thankful to Dr. M.A Sabur and Dr. A Z M Zakir Hossain for providing me the basic information about my research. I would also like to thank the respondents for their cordial help and assistance during field survey. Without their help it might not be possible to collect data efficiently.

Special thanks due to my colleagues and friends at North south university for their unconditional support to overcome all the hurdles during the course especially in writing the thesis.

Last but not the least I would like to express my thanks to my family who showered me with love, inspiration and support to make me my work done.

Md. Golam Rabbani
North South University, Dhaka
June 2010.

CHAPTER ONE

Introduction

1.1 Introduction:

Public policy making is not only a simple function, but also a process where different actors interact and try their best to influence the policy. Policy process and dynamics of politics is interrelated. The main aim of this study is to uncover the dynamics of politics in the agenda setting of the health policy of Bangladesh through investigation of the role of deferent actors. This chapter consists of discussion on statement of the problem, literature review, objectives and methodology of the study.

In every policy process[1] politics play an important role in idea generation, formulation and implementation (Peterson, 1993; Cited in Reich 1995). Policy reform in health sector is not different from other policy reforms. In the process of health policy making of any country, different actors try to bring the policy in their favor through playing significant role. This interaction of deferent actors in policy process is known as politics of public policy. In the complex political process of health sector reform viability of special agenda, type of changes in policy reform, vision of national politics play an important role. (Oberlander, 2003; Roper, 2007). Generally, different actors have their won choices and preferences which are shaped by interest group politics[2] and national politics. But, it does not necessarily mean that group politics only play the dominant role in the policy making. Rather public opinion and voice of donors bring a significant change in public policy (Oliver and Dowell, 1994). The case of health policy making of Bangladesh is not an exception.

In Bangladesh, health is one of the most important sectors since good health ensure more social and economic production and good quality of life (Berry & Joe 2001). Beyond debate, priority of the health sector is forefront in the development discourse, even though, 'health sector' itself is associated with multi sectoral factors and actors (Perry 2000). Thus, making implementation of health sector policy requires interplay of actors and factors from different sectors and levels (local, national, regional and international) (Rob and Talukder, 2007). Public policy making in third world countries is not merely a simple function (Rahman, 1995 cited in Panday 2001). And when it comes to making of health policy of developing country,

[1] Policy process refers to interlink among problem identification, problem recognition, policy formulation, implementation and evaluation in a specific policy.
[2] Interest group politics mean politics among the core stakeholders who have specific interest.

it is multi-sectoral than any other policy since huge number of health issues and its associated issues require urgent attention (CSG, 2008). Numerous actors and factors play crucial role in health policy process of Bangladesh, (Howlett and Romesh, 1995; Aminuzzaman, 2002, Osman 2004). In the total policy process, agenda setting is more important since actors (Individual or groups) come forward with their (policy actors) ideas and issues in this stage. Thus, different dynamics occur in this stage. Actors' expertise, access (including network), information, authoritative and influential position and strategy to highlight the specific issues are main determinant factors to draw serious attention by government. Main focus of this study is on the dynamics of agenda setting in health policy of Bangladesh. In order to find out the dynamics of agenda setting, role of the different actors have been investigated. To make the study more specific, community health related agenda setting in 'National Health Policy, 2010[3]' was chosen as a case.

1.2 Statement of the Problem:

Till today, health situation in Bangladesh is not quite satisfactory. Lack of broad national health policy or policy vacuum, lack of policy priority setting, discontinuity of policy, lack of policy ownership, lack of resource (human and financial) allocation and lack of proper uses of resources due to lack institutional arrangement and elite dominated health sector (Perry 2000, Osman 2004; Sundewall, Forsberg and Tomson, 2006; Mabud 2007) are the main characteristics of health sector in Bangladesh. These characteristics create hindrance in the process of achievement of national and international goals and ultimately health situation of common people remains vulnerable.

1.3 Illustration of the Problem:

A remarkable success was found in health sector of Bangladesh in terms of reduction of mortality rates, increasing life expectancy at birth, the spread of family planning activities, and substantial reduction in fertility rate since 1980s despite rigid socio-economic environment (Mabud, 2007). Government of Bangladesh (GOB) put priority on the health sector for the betterment of its total population. Since independence GOB has been implementing different types of programs and projects. As compared to past different initiatives of the government is appreciable but these initiatives did not bring enough satisfaction in the health situation of Bangladesh In Bangladesh newborn mortality rate is 36

[3] Previous 'National health policies' of Bangladesh have covered maximum issues on health. Basically health policy is a package for providing the health services in Bangladesh.

per 1,000 live births, infant mortality rate is 54 per 1,000 live births, under -5 mortality rate is 73 per 1,000 live births (UNICEF 2007). If we consider national average, the situation is not bad. But from the ground of equality, equity and justice, this situation is not satisfactory. In 2004, when the national average of infant and under-five mortality rate (per 1000 live births) was 72.4 and 96.6 respectively, then the lowest quintal (5th) infant and under-five mortality rate was 89.7 and 121.1 respectively (HNP,2007).

Prevalence of different diseases and health services receiving scenario is not equal on the basis of wealth index, rural, urban, slum and tribal. For example prevalence of diarrhea among the children in rural, urban, slum and tribal areas are 7.1, 7.4, 11.2 and 5.1 respectively while 32.8 percent affected tribal and 28.6 percent slum dwellers didn't take any treatment (MICS, 2006). From this perspective it is clear that disadvantaged people are more vulnerable than the general people. The above picture is the partial view of health status of Bangladesh. There is a lacking in setting priority in health sector (Perry, 2000 and Mabud, 2007). The usual life span of a public policy in Bangladesh depends on the change of political power and the health policy is not an exception. Change in government brings change in the visions and directions of health policy of Bangladesh. (Osman 2008 and Mabud, 2007). In addition, several researches found the existence of excessive donor control in the health sector of Bangladesh. Due lack of initiative in national priority setting, shift in visions and direction with the change in regime, policy maker and field level bureaucracy, create hindrance in the process of building ownership which ultimately hampers the policy implementation. In the literature of policy ownership, source of ideas/visions is treated as one of the major indicator to measure the ownership of policy (Osman, 2005). In public policy process 'agenda setting' is a stage where owner of ideas/visions and promoters of the ideas take different strategy to draw the attention of the policy makers.

Government has already taken initiatives to formulate the 'National Health Policy, 2010' and now content has been prepared and the policy is now at approval stage. As stated before, this study intends to reveal the dynamics of inter-play of different actors in agenda setting of health policy in Bangladesh.

1.4 Literature Review:

In this study several national and international literatures has been reviewed. While reviewing literature, literature was selected very consciously. Among reviewed literature, some major findings which seemed relevant to health policy of Bangladesh are given bellow:

Osman (2004) studied the process of formulation and implementation of health sectors plans in Bangladesh up to 2000. The study finding presented a comprehensive account of the dynamics of health policy process.

Perry (2000) provided an in-depth assessment of numerous health and family planning activities having particular emphasis on some factors that influenced the health service delivery in Bangladesh.

Mabud (2007) described the chronology of health services delivery in Bangladesh having particular emphasis on identification of factors causing failure in the implementation of health services delivery. This writing was more focused on causes of implementation failure in health service delivery.

Jahan (2003) illustrated how advocates for gender equity succeeded in influencing the restructuring of the health system in Bangladesh in the mid-1990s. The study explored the impact of advocates for gender equity made in the design of the reforms.

Shiffman (2003) drew political science and public administration theory to evaluate the Bangladeshi reform experience in the health sector. The study did so with reference to the norms of efficiency, effectiveness, sovereignty and democracy.

Reich (1995) examined the political dynamics of health sector reform in poor countries, through a comparative study of pharmaceutical policy reform in Sri Lanka, Bangladesh, and the Philippines having a special focus on political will, political factions, and political survival models.

Above mentioned findings substantiate existence of political dynamics in the health policy process in Bangladesh. But very few researchers emphasized on political interplay among the actors in health sector of Bangladesh. Thus, the issue of dynamics in agenda setting in Bangladesh deserves special attention for further exploration.

1.5 Scope of the Study:

Health sector consists of a number of sub-sectors and closely liked with other sectors. So, health policy deals with lot of issues and subjects. To make the study more precise, agendas about community health related issues were given h special attention.

1.6 Objective of the Study:

General objective of this study was to explore role of different actors and factors in agenda setting of health policy of Bangladesh.

1.7 Research Questions:

In order to explore answer of above general objective, following special objectives were raised:

1. Why do/does problem/problems (specific issue as a problem) get priority as subject /subjects of policy decision in the health policy of Bangladesh?
2. How do proposals come to the consideration of government decision makers in the context of health policy of Bangladesh?
3. How do political factors influence the agenda settings in the health policy of Bangladesh?

1.8 Rational of the Research:

'Health' sector, itself is very important sector for any nation, especially for developing nation. Like other developing nations, health situation in Bangladesh is a developmental problem and without addressing this problem development initiatives in Bangladesh cannot be successful. Thus, to develop the nation and to ensure the quality of life of every citizen a big push was necessary in the health sector. Without the existence of a sound policy process, health system and health situation cannot be reached up to the mark. As a matter of fact policies guide the implementers to take feasible and objective oriented decisions in a specific context. In the context of Bangladesh, successful policy implementation is a rear happening. So, the health sector of Bangladesh is not an exception in this regard (Walt & Gilson, 1994, Grieve 1995, Nazneen 2001). Poor situation of health is an indication of the policy failure in health sector of Bangladesh (BDHS, 2007; Osman, 2004; Jahan and Masudus 2006 and Perry 1999). Now a pertinent question can be raised: where lies the gaps in the policy process? Different researchers have tried to unearth the causes of implementation failure of deferent project and program, but very few attempts has been taken to explore the dynamics in the policy process, especially in agenda setting where main politics play an important role. It can be argued that without considering political dynamics it would be very difficult to understand the policy process. Thus, agenda setting in health policy deserve an important position in the academia and practical or real field. Further more, recent dynamics took place during 2007 to February 2010 while the draft of the 'National Health Policy' in Bangladesh was finalized. Thus, it can

be claimed that an attempt to explore the political dynamics of agenda setting in health policy of Bangladesh is a contemporary phenomenon which needs urgent attention.

1.9 Logical Framework of the Study:

After analyzing and assessing scope of work and finalizing objectives of the research, following logical framework has been developed. The logical frame consists of research questions, sources of data, methods of data collection methods and expected output.

Table 1.1: Logical Framework of the Study

Research Questions	***Measurable Indicator***	***Methods***	***Means of Verification***
Why does/do Problem/problems (specific issue as a problem) get priority as subject/subjects of policy decision?	Situation of Community Health, Status of Services, Interest of Different Actors	Key Informant Interview and Content Analysis	Cross-checking one respondent's information with others
How do proposals come to the consideration of government decision makers?	Findings (Research findings) , Evidence (learning from program policy or model) and commitment (National and international commitments- constitution, national and international declaration or goal)	Key Informant Interview and Content Analysis	Triangulation
How do political factors influence the agenda settings	Political will (like as election manifesto) and leadership (Any leader's enthusiasm to make the policy)	Key Informant Interview and Content Analysis	Triangulation

1.10 Methodology:

The study is qualitative and explanatory in nature. Mixed method approach (both quantitative and qualitative) has been used in this study. To analyze the politics of agenda setting case study is an ideal methodology since holistic and in-depth investigation is possible through this method (Feagin, Orum & Sjoberg, 1991). In this research, an exploratory and descriptive case study approach was used because how, what, and why questions have been posed. In this study both primary and secondary data have been collected to explain the objectives of the study.

1.11 Sample and Subject Selection Criteria:

Due to time and resource constraints it is not possible to conduct a study on the whole population who are associated with the process of health policy making. Thus, subsets of

population were chosen through sampling. In the current study's context, the sample sizes were determined on the basis of the principles of Snowball Sampling[4]. In this study, fifteen individuals were selected as respondent. In this technique, first subject was identified with serious attention and then the respondent was asked to identify the other potential subject. In every policy making process, there is a hidden class of actors who are potential and play influential role. As an outsider it is very difficult to find out the informed respondents. Moreover, there was no official committee to formulate the National Health Policy 2010.

1.12 Data Collection:

For the most part, qualitative data was used in this study supplemented by quantitative data whenever appropriate. In Creswell's term (1994:177), this could be termed as a dominant – less dominant design. Here, the dominant design is the qualitative data, while the less dominant one is quantitative data.

1.12.1 Primary Data: Primary data were collected through a semi-structured interview questionnaire having both closed and open-ended questions.

1.12.2 Secondary Data: Secondary materials were gathered from different published sources such as, books, book chapters, articles, unpublished dissertations, newspapers, and internet browsing.

1.13. Data Validation Technique:

Following techniques were used to validate the collected data.

1.13.1 Pre-testing:

Key Informant Interview guidelines were pre -tested. Pre-testing helped the researcher to connect the theory with reality.

1.13.2 Cross-Checking:

In this study one respondent's view was cross-cheeked with other respondents. Also primary data was re-cheeked with relevant secondary data.

1.13.3 Triangulation:

Denzin (1978) used the term "triangulation" to argue for the combination of methodologies in the study of similar phenomena. Thus, effort was made to use a combination of qualitative and quantitative methods in a single research.

[4] Snowball Sampling is a technique whereby interview subjects are asked to identify other potential subjects and the study sample "snowballs" in the size the successive round of interviews.

1.14 Data Management Plan and Analysis Plan:

Data was recoded and transcripted manually. To manage the qualitative data tabulation was prepared. Every interview was analyzed separately and findings were re-checked with the views of other respondents. As per chapter outline collected data were arranged in different folders.

1.15 Generalization of the Study:

In this study analytical generalization technique was used. To generalize the study findings, it was supported by other previous research findings or observation.

1.16 Chapter Outline:

The thesis is organized in seven chapters. **Chapter one** explains the background to the study, states the research problem and methodology of the study. It specifies research objectives and research questions. Further, it also focuses on the rationale and significance of the study.

Chapter Two - Theoretical Framework and Conceptual Clarification- This chapter described the existing theories of agenda setting, uses of these theories in this study and clarifies the used terminology.

Chapter Three –- Problems, Policies and Politics in Health System- presents a historical account of heath system of Bangladesh highlighting the health problems, policies and politics in agenda setting of health polices of Bangladesh.

Chapter Four - Problem Stream- This chapter highlighted the process under which community health is given priority over several other competing issues.

Chapter Five- Proposal Stream- In this chapter we discussed how proposal or proposal recognized by the policy decision makers.

Chapter Six- Politics Stream- In this chapter discussed how political parties play the role in agenda setting of community health.

Chapter Seven- Discussion and Conclusion: In this chapter analyzed the studies findings. It provides a brief discussion on to what extent different actors played their role in agenda setting.

CHAPTER TWO

Theoretical Framework and Conceptual Clarification

2.1 Introduction:

A theory is a set of established knowledge that has been repeatedly tested to explain or predict facts or phenomena. Theory provides a conceptual framework and it guides action. In this chapter we discussed theory of public policy and agenda setting and a theoretical framework was prepared based on these theories to make the study more authenticated and focused.

Public policy is a complex phenomenon which is interlinked with numerous decisions making of different actors and organization (Howlett and Romesh, 1995 : 7). 'Public policy' is well known as policy process and this process is very complex in every country. And to understanding the process is also very complex.

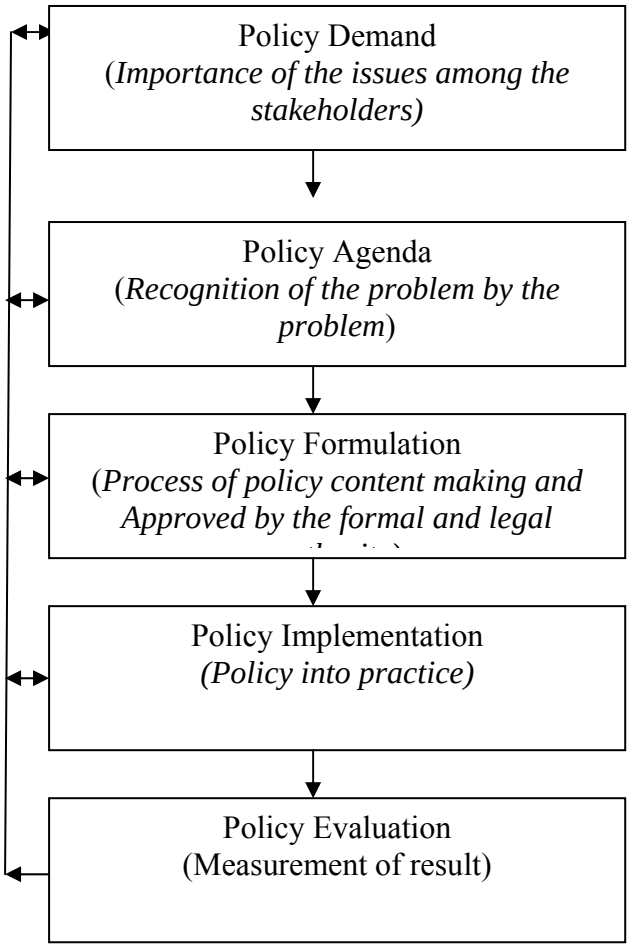
According to Mason et al. (2002), policy "encompasses the choices that a society, segment of society, or organization makes regarding its goals and priorities and the ways it will allocate its resources" (Cited in, Malone 2005).

When policy is made by government to attain a specific objective this is called public policy. Some established definition of public policy:

> According to Thomas Dye, "any thing a government chooses to do or not to do'. (Cited in, Howlett and Ramesh, 1995)
>
> James Anderson describes, "A pervasive course of action followed by an actor or set of actors in dealing with a problem or matter of concern.'' (Cited in, Howlett and Ramesh, 1995).

Political scientists devoted to public policy issues since the early 1970s for providing conceptual grounding for public-policy analysis. This framework consists of discrete phases or stages associated with the policy process (Anderson, 1978; Cited in Howlett and Romesh, 1995 : 11). Some political scientists have identified as many as seven stages in the policy process, but the most conventional rendering cites only five. The stages are usually arranged sequentially, as depicted below, and include a feedback loop.

Figure 2.1: Public Policy Process



The above mentioned stages are interlinked and every stage has it own significance to catch the attention of policy analysis. The following sections provide a preliminary discussion of each stage of the policy cycle, recognizing the political dynamics in each stage. It will be shown that different actors have role to play in each stage, but plays a greater role in some of them than others.

2.2 Agenda Setting:

Agenda-setting is a political process which is conflictive and competitive. There is an infinite number of policy issues that could reach the agenda of decision makers. Political scientists have been quite active in researching the process by which issues gain ascendancy to catch the attention of policy makers. But to portrait the means and mechanism by which issues and concerns are recognized as subject for government action is not simple. Also manner and forms of recognition from the government varies across policies (Howlett and Romesh,

1995). To make the agenda setting more understandable we described some scholarly definitions in the following discussion:

> According to Dearing and Rogers (1996), "the agenda setting process is an ongoing competition among issue proponents to gain the attention of media professionals, the public, and policy elites."
>
> Cobb, Ross and Rose defined agenda-setting as "the process by which demands of various groups in the population are translated into items vying for the serious attention of public officials" (Howlett and Romesh, 1995 ; P.105).
>
> A more descriptive and practical life oriented definition is provided by John Kingdon, "The *agenda* as I conceive of it, is the list of subjects or problems to which government officials, and people outside of government closely associated with those officials, are paying some serous attention at any given time…….Out of the set of all conceivable subjects or problems to which officials could be paying attention, they do in fact serious attend to some rather than others. So the agenda-setting process narrows this set of conceivable subjects to the set that actually becomes the focus of attention" (Howlett and Romesh, 1995 ; P.105).

Above mentioned definitions depicted that competition is integral part of agenda setting. Similarly, competition invites politics in agenda setting, because all interested parties do politics to promote their agenda in the policy arena. Some factors act as basis of politics and considering these factors interest groups plays vital role to get the recognition. These factors are given below in following-

2.3 How do issues/themes become part of the agenda?

There are varieties of political, social, and ideological factors which play vital role in case of gaining access as candidates for government action for resolution. As well, interest groups take necessary steps based on the characteristics of these factors.

In the following discussion we discussed some factors which have vast influence to promote a specific problem as policy agenda.

- Weight of the problem
- Information/evidence from evaluations and existing programs reveals that a situation (because of harshness, extent, significance number of people affected or , etc.)requires attention.
- Values, beliefs or motivations can turn a condition or situation into a problem.
- Collective action of interest groups, protests, lobby, social movements around a particular topic.
- Role of the media.
- Political changes. (Barbados, 2007 & Howlett and Romesh, 1995)

2.4 Why do some issues not make it?

There are some other factors which play as hindrance in the way of promoting an individual problem for government action. These factors are also related with problems, will of decision makers and strategy of interest groups. In the following discussion we pointed out these factors.

- Problem Definition
- Crowded Out (by other issues)\
- Problem not recognized as a relevant issue/problem
- Low political attention
- Low recognized by broader policy guideline
  (Barbados, 2007 & Howlett and Romesh, 1995)

2.5 Theoretical Framework: Established Theory in Agenda Setting

Agenda setting is the most basic stage of public policy cycle which is concerned with identification policy issues and placing these issues on the agenda of government. To promote an idea as a policy agenda requires participation of different actors in a competitive process. Till know participation in policymaking is a central question in the discipline of Public Policy. Role of interest groups and public[5] in shaping administrative decision was the main theme of early pluralist's work (notably Truman,1951, Cited in, Robinson and Eller 2010). In here public participate directly as interest group and indirectly, through the influence of elected officials. Later works which is popularly known as elite theory (work of

[5] In here public means general people

Lowi, 1979; Cited in, Robinson and Eller 2010) focused on the dominance of political elites, bureaucratic elites and business elites in policy making process. As a result of the pluralist/elitist debate over participation in administrative policymaking new model of policy decision making emerged. Cohen, March, and Olsen (1972) mentioned that organizations do not take decisions in a rational way (Cited in, Robinson and Eller 2010. Moreover, rational self-interest is more dominant in organizational decision making (interest of conflicting interest groups, from the pluralistic or the interest of elites). In the competitive environment organizations take decision haphazardly based on of a series of "streams" (the coming together) of organizational inputs. This is popularly known as garbage can model (GCM) of organizational decision making. Kingdon (1995) applied this model of organizational decision making to the policymaking processes. Kingdon described that policy processes are neither elite nor pluralist in their entirety. Instead, completion was found separate "streams" of policymaking activity among pluralist forces and elite forces.

According to Kingdon's view an issue becomes agenda with three confluence "streams"

- Problem stream
- Proposal stream
- Politic stream (Laraway and Jennings 2002).

2.5.1 Problem Steam:

Problems refer to the process of persuading policy decision makers to pay attention to one problem over others. It can be influenced by how problems are learned about (e.g., through data or indicators) or defined (e.g., framed or labeled). In this steam different actors try to influence the policy makers highlighting the problems with different findings and evidence.

2.5.2 Proposal Steam:

Proposals represent the process by which policy proposals are generated, debated, revised, and adopted for serious consideration. Proposals are likely to be more successful if they are seen as technically feasible, compatible with decision maker values, reasonable in cost, and appealing to the public.

2.5.3 Politics Steam:

Politics are political factors that influence agendas, such as changes in elected officials, political context or mood, and the voices of advocacy or opposition groups.

These three elements operate largely independently, although the actors in each can overlap. Successful agenda setting requires that three steams come together at a critical time and then a "policy window" opens. (Kalu 2005, Kelly 2005). Through this window specific agenda become a subject of policy decision.

2.6 Agenda Setting and Policy Sub-System:

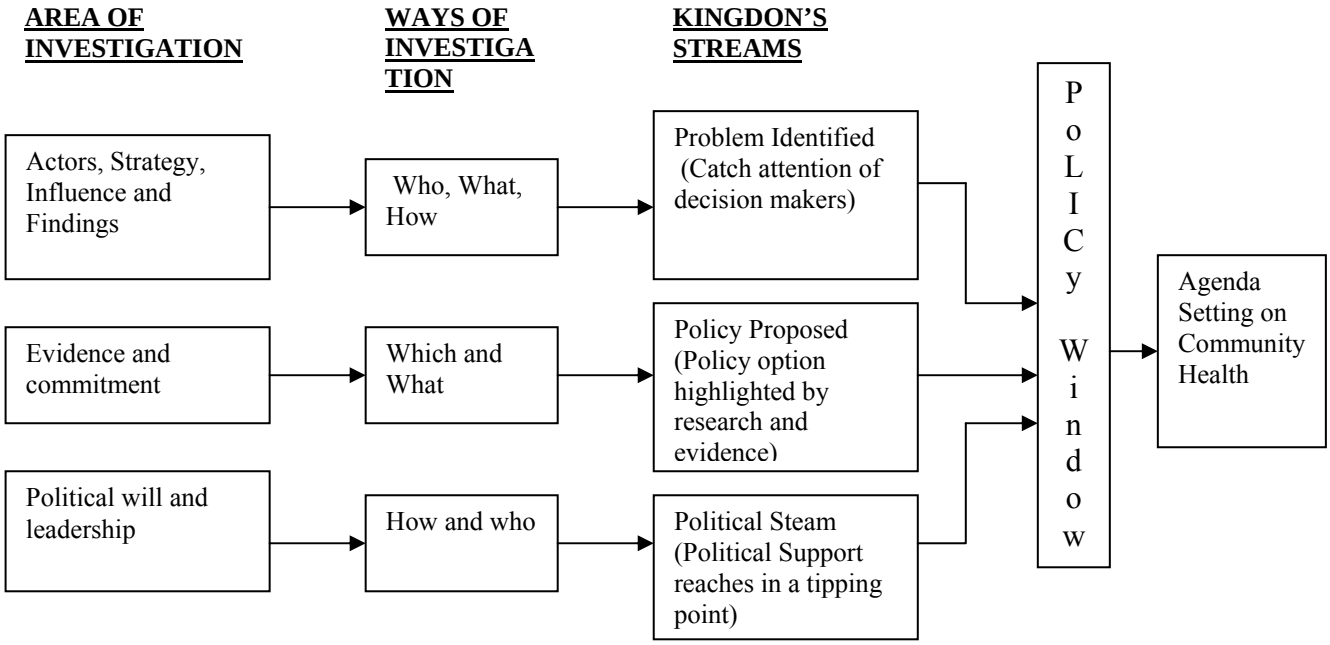
Agenda setting process happens in a specific policy environment which is consisted with different factors, like as economic political, social, geographical, demographical, cultural, institutional, international etc (Malone 2005). In this complex interaction both actors and institution play their roles which are shaped by different factors. Some of these are involved in the process due to their formal authority, to promote the agenda, some to provide technical, financial and other kinds of support, while others are to advocate their own interest (Rhodes, 1997). In public policy all actors are generally divided into two- parts; as in; state/government actors and societal actors/non-government actors. Elected officials (The Executive and legislature) and appointed officials reside within the state and interest groups, research organization and mass media reside within societal actors or non-state actors. (Romesh and Howlett, 1995). In every country these two actors play vital role, but both may not present equal influence. Role and influence of actors depend on nature of interest, capability, technical knowledge, power of actors as well as intensity of the importance of the factors and above all on the dynamics of the role of these factors and actors (Verschuere 2009). Like as other developing country public policy making goes trough a complex and ambiguous process. The process is ambiguous and complex because there is no formal, established and visible process and institutional arrangement in public policy making of Bangladesh (Aminuzzaman, 2002).

2.7 Analytical Framework:

While there is no neat way to package the policy process (more focus on agenda setting) to explain all of its complexity and nonlinearity but widely used kingdon's theory can help to capture the maximum facts and figures in health policy making in Bangladesh.

The following will be an elaborative illustration of analytical framework of this research:

Figure 2.2: Analytical Framework of the Study



2.8 Conceptual Clarification:

Meaning of concepts varies from context to context. In this study we used some concept. The operational definitions of these concepts were discussed in the following discussion.

2.8.1 Policy Process:

Policy process refers to interlink among problem identification, problem recognition, policy formulation, implementation and evaluation in a specific policy (Sutton, 1999). In this study, we gave special attention on agenda setting of community health issues in Bangladesh.

2.8.2 Community Health:

Community health tends to focus on geographic areas rather than people with shared characteristics. In other worlds community health deals with health problems of common people of a specific area. In this study community health means health situation and health services at village level.

2.8.3 Policy Network:

A policy network consisted with a group of individuals and organizations that share similar belief systems, codes of conduct and established patterns of behavior (Sutton, 1999; Howlett and Romesh 1995).

In this study we tried to explore the role of individuals, research community, NGOs, international organizations or a range of other organizations in community health related agenda setting.

2.8.4 Policy Community:

A policy community is a more tightly-knit group of elite experts who have access to certain information and knowledge, which excludes those who do not have such access (Sutton, 1999). In this study community means village level rural community.

2.8.5 Policy Environment:

Policies are developed in specific socio-economic context and it never exists in a vacuum. The context is extremely important because it shapes the ideas and actions. Policy environment consist with local, national and international factors and actors. Nature of policy environment varies policy to policy (Rodrigue, Comtois and Slack 2009).

In this study policy environment means a surrounding environment where dynamics of politics occurred in the time of community related agenda setting.

CHAPTER THREE

Problems, Policies and Politics in Health System: Historical Perspective

3.1 Introduction:

Policy research heavily depends upon contextual variables. The dynamics of politics in the process of public policy not only varies from sector to sector but also has a variation from context to context. Keeping this connection in mind the following chapter focused on the context of health policy in Bangladesh – prior to 2009 - with special emphasis on problems, policies and politics issues.

3.2 Health System in Bangladesh:

Bangladesh, being a country with small land size of 144,000 sq. km, has the burden of a huge population of 140 million. Still, with low per capita income and low literacy (52.8 per cent). The government driven healthcare service has a network in all over the country from the centre to the extreme periphery (Upto Union Level[6]). The entire health system of Bangladesh gets controlled by the Ministry of Health and Family Welfare (MOHFW), having two wings, one concerned with Population and Family Planning and the other concerned with Health in total. The service network has three approaches with primary care at *upazila* (sub-district) level; secondary care at district level; and tertiary care at divisional level. To administer administrative activities the country has six administrative divisions and 64 districts and furthermore the districts are divided into *upazilas* (476 in number) and *upazilas* into unions (4,770). It is estimated that each of the union consist of 25,000 people in most cases each of the unions are again divided into nine villages (Chowdhury 2004). The *upazila* health complexes (463) acts as the first referral centers for primary health care along with one district levels hopistals at all districts (64) and most of the specialized hospitals resides at tertiary levels, mostly in Dhaka – the capital of Bangladesh. (Siddiqui 2003)

There is a standard setup for health services in an *upazila* consisting of one *upazila* health complex, one union health & family welfare center (UHFWC) at union level (4062) and community clinics at village levels for every 6000 populations. It is mentionable that the community clinics were established under the Health and Population Sector Program (HPSP) - a donor driven mega program – were not functioning till now and being revitalized in recent periods (from the regime of interim caretaker government to present AL government) .

[6] Last tire of local government and administrative set up in Bangladesh

Apart from general health services other services i.e. minimal reproductive, maternal, and child health care services get provided by these centers for the local people free of cost. The ratio of physicians and registered nurses to population is 241 and 136 respectively per million people and the number of hospitals available for a million people is 10, while the the availability of hospital beds is one for about 4000 people (Siddiqui 2003).

Non government organizations (NGO) and private sectors also play an important role to provide health services for the country. Numbers of NGOs have targeted projects, program and facilities to provide antenatal care (ANC) and safe delivery care. Besides in urban areas the number of private service delivery centers and private physicians are also on the rise. Thought the private clinics get operated privately, most of the doctors working in public hospitals work there on part time basis. These clinics have high charges and operate on commercial basis and people living in highest quintiles prefers such clinics for good quality service, which sometimes is not available in public sectors, as per the wealthiest quintiles perception (BHW, 2007).

3.3 Health Problems:

Though Bangladesh has one of the strongest networks for delivering countrywide health services among developing countries, still the quality of services are not up to the mark and the services are neither client focused nor need based. In the following tables we demonstrated the trends of basic health indicators of Bangladesh-

Table 3.1: Trends of Basic Health Indicators of Bangladesh

Indicators	1970s (1978-80)	1980s (1990)	1990s (1996-97)	2000s (2003)	2007
Population growth rate	2.7	2.10	1.74	1.54	NA
Infant Mortality Rate (Per 1000 live births)	150	110	77	66	52
Under 5 Mortality Rate (Per 1000 live births)	229	110	116	94	65
Maternal mortality Rate	10	5.7	4.1	3	NA
Delivery Care by trained personnel (%)	2	5	8	12	18

(Source: Cited in Osman 2007)

3.4 Health Policies:

The existing health system of Bangladesh is the outcome of many policy shifts and changes. During independence, the country had an urban-based, elite-biased and curative health

system which was rather limited in terms of medical facilities and services. As time passes, the countries health system has been fined tuned to a great extent by shifting the policy focus from urban to rural and curative to preventive perspective. Such a policy shift has produced number of tangible outputs which gets considered as an indicator lesson for other developing countries (Osman 2004).

Prior to the 2000, the countries healthcare system was running under the guidance of long-term Five Year Plans and in addition to these policy documents there was sector wide strategy known as the Health and Population Sector Strategy (HPSS). The broad goals of all these policy documents were to reduce population growth, ensure access to primary healthcare services and provide maternal and child healthcare services to the poor and disadvantaged sections of the population. With these objectives, the first Five Year Plan (1973–78) adopted the strategy of establishing health infrastructures along with capacity building of health professionals. Subsequently, the construction of health centers at union level and health complexes (31 bedded hospitals) at the *thana* (sub-district) level also began (Osman, 2007).

In relation to this the first population policy got adopted in 1976 and the successive Five Year Plans was closely influenced by this policy. The key strategy of the population policy was to provide comprehensive health and family planning services primarily through service centre i.e. clinics and female field workers, with strong emphasis on doorstep services to rural women (Bangladesh Health Watch 2006). The policy also emphasized public private partnership. In 1977 the government sensed the need for private sector participation in health service delivery (Osman 2007 and Perry 1999).

And this was reflected in the interim Two Year Plan (1978–80) and in Second Five Year Plan (1980–85). The fifth Five Year Plan (1997–2002) included few new strategic issues influenced by the Health and Population Sector Strategy (HPSS) adopted in 1997. The HPSS provided the health sector a new direction towards efficiency and cost-effectiveness by advocating certain institutional and governance reforms. It fed into the fifth Five Year Plan (1997–2002) and the National Health Policy was eventually approved on August 14, 2000. As these three documents were adopted at same period of time, these three documents are much similar in their respective strategies. In 1998 the operational plan of HPSS, known as Health and Population Sector Program (HPSP) (1998–2003), was launched which acted as a major reform of health program in the country. Later on the component “Nutrition” got

included and HPSP got renamed as HNPSP which has a strong emphasis on improving access to and utilization of essential services particularly maternal health services by the poor. And as mentioned all these policy changes and innovations have shaped the present health system of Bangladesh (Perry, 2000; Osman 2004,Osman 2007) .

In addition to the aforesaid policies another health policy was drafted in 2006 by the BNP government which eventually failed to obtain the final approval from the cabinet. That health policy had a total of 19 objectives, 20 principles and 28 strategies. In terms of policy directions, the NHP 2000 was more generic than that of draft NHP 2006. Apart from that there were very less fundamental variations between both the NHP's in terms of major policy issues. Both emphasized the vision of providing health services for all through primary health care and both proposed the unification of health and FP wings as a key health sector target. But in NHP 2000, "community clinics" and facilities were mentioned as "for every 6,000 people", which was mentioned as establishment of the ward level "first contact centers" in NHP 2006 with similar purpose as like as community clinics. In 2008, an attempt was taken to update the health policy focusing on the poor and the disadvantaged keeping the continuity of certain elements of the existing health policy with some additions as main feature. It included certain new elements i.e. non communicable diseases, urban health service, climate change related health risks and mitigation measures, medical waste management, food safety and quality and added focus on stewardship role of the government (BHW, 2010).

Though both 2000 and 2008 policy documents had specific objectives, both lacked omitting specific strategic directions. The 2008 draft did not mention the revitalization of community clinics and only noted the importance of developing health policy. Moreover keeping a similarity to NHP 2000, it focused on primary health care, ESP, maternal and reproductive health, accountability of professionals, user fees as resource generating mechanism etc. The ruling government of Bangladesh has made a declaration to update and re-formulate a new national health policy, the process of which is going on (BHW, 2010).

Table 3.2: Chronological Development of Health Policies

Time	Main Theme/ Initiatives /Objectives
1970-71	Urban and elite-biased curative health system
first Five Year Plan (1973–78)	The strategy of establishing health infrastructures (Thana and Union Level) along with capacity building of health professionals
First population policy 1976	To provide comprehensive health and family planning services primarily through service centre i.e. clinics and female field workers, with strong emphasis on doorstep services to rural women
Two Year Plan (1978–80)	Reflection of First Population Policy
Second Five Year Plan (1980–85).	Health for All within 2000 and Primary health Care
Third Five Year Plan (1980–85).	Emphasized on Mater Child Health under Primary Health Care
Fourth Five Year Plan (1980–85).	Emphasized on Mater Child Health under Primary Health Care
Fifth Five Year Plan (1997–2002)	Essential Service Packages of Health Services and Unification of Health and Family
Health and Population Sector Program (HPSP) (1998–2003)	Sector Wide Approach in Health Sector of Bangladesh. Efficiency and cost-effectiveness by advocating certain institutional and governance reforms
National Health Policy 2000	All the basic services under Essential service package are being delivered through one-stop service centers at the *Upazil* (UHC), Union (UHFWC) and partially at the village
Health Policy 2006	
Heath Policy Update 2008	Update the health policy focusing on the poor and the disadvantaged keeping the continuity of certain elements of the existing health policy with some additions as main feature.

(Perry, 2000; Osman 2004,Osman 2007, BHW 2010)

3.5 Recent Politics in Health Policy Making:

Like many other developing country the lifetime of a public policy in Bangladesh depends on the change of political power and health policy is no exception. Visions and directions of all health policies got changed with the change of ruling government. Likewise the NHP 2000, was also interrupted as the government changed. After that two attempts were made to revise the policy till 2008. This instigated disruption in policy implementation rather than bringing any positive change. Many arguments took place in favor of policy reversal by the policy actors but the decision remained absolutely political. The following subsection illustrates the policy vulnerability of NHP 2000 as reflected in its reversal and formulation of NHP 2006 and 2008 and the political dynamics behind it (BHW, 2010).

The first and fully operational national health policy was initiated in 1988 during the autocratic regime. In 2000 the democratic government promulgated a national health policy with five goals and objectives, in October 2001 after the Bangladesh Nationalist Party-led coalition government came to power. This new government deviated from NHP 2000 and got engaged in redrafting a new health policy, without rejecting the existing one in its entirety. This NHP 2000 was to some extent rejected when two of its essential components related to structural transformation were made dysfunctional. The issues were i) unification of health and FP wings ii) the issue of community clinic. Key policy actors (both politicians and bureaucrats) had staid uncertainties about the outcome of these two major reforms and believed that these two issues introduction had been politically motivated by Awami League (AL), which finally resulted in non-implementation. The following segments give an outline of how two major reforms proposed by the policy faced rejection. (Osman 2007 & BHW 2010).

Integration or unification of health and FP wings - the cornerstone of the NHP 2000 – was formally approved earlier through the HPSS and HPSP (1998-2003), did not experience smooth implementation even during the AL arena. This unification was intended to provide health and FP services in a package for improved service efficiency by minimizing duplication and overlapping of service delivery, which did not take place due to bureaucracy (Sundewell & *et .al* 2006).

During the era of 2001-2006, reversal of NHP 2000 became the interior of a whirlpool of conflicts, delays, and difference among policy players, including the bureaucrats, politicians, medical professionals and donors. At the early stage of BNP regime, the system of government held substantial power over the execution of NHP 2000. And the final decision on reversing unification was taken by the Health Secretary and the Prime Minister. The new senior level bureaucrats during this period contrasted the amalgamation and community clinics. The bureaucrats believed that incorporation would marginalize the FP section of the health sector, when it was decisive to uphold the responsibilities and sovereignty of the FP workers. The ruling BNP leaders were rigid to renounce the NHP 2000 since it was formulated by the previous AL government. And political leaders played a fundamental part in the policy implications during 2001-2006. It has been observed that the harmonization between the medical professionals and political leaders led to dealings with the bureaucrats and other forces and exercise more power (BHW 2010).

The partial refusal of NHP 2000 can be accredited to the customs of confrontational politics and prejudice that permeates every level of the polity, rather than ideological dissimilarity of the political parties. There was little ideological difference between the BNP and AL governments, as demonstrated in similar policy proposals of the two respective health policy documents (Osman 2007).

3.5.1 Health Policy 2006 Draft Preparation:

With number of changes and interruptions taking place in health sector programs, goals and priorities, NHP 2000 was no longer considered as a suitable policy document for the ruling government, which felt that the need to be formulated an amended NHP. In July 2003, with the initiative of the MoHFW, a 58-member Core NHP formulation committee was formed, headed by the Health Minister. In August 2006, three years after the reconsideration procedure started, the draft policy was approved by the Ministry but it never reached the Cabinet level and was not eventually finalized. By then, with the general elections coming up, the government had other priorities, which did not include finalizing the policy document (BHW, 2010).

In the meantime, the BMA prepared a health policy in its own forum in 2004 and NHP 2006 was heavily influenced from BMA's version of the NHP, having similar proposals documented in both documents. Both were prepared by a common group of people since BMA representatives were also closely involved with the NHP 2006 formulation process.

Formulation of NHP 2006 was mainly motivated by the political leaders and medical professionals. The bureaucrats were not as active in the 2006 policy making process as they were in case of NHP 2000. Donors and civil society also had little involvement. In the end the policy could not see the light since the political leaders did not contribute to finalize the NHP 2006 (BHW, 2010).

A nexus between the ruling party and the medical profession revitalized the policy reformulation procedure further. Medical professionals became extremely significant in the second half of the government when politicization of various medical associations became intensely evident and was associated with increased opportunities for altered form. As the government used politically slanting people for professional work, DAB came out as an influential body that influenced vital decisions made by the Ministry (BHW, 2010).

Bureaucrats were absent in reformulating the policy as they were in reversing the NHP 2000. During 2001-2006 when the policy revision started, authority of bureaucrats in policy procedure windswept significantly. They had less authority and therefore, in NHP 2006 formulation process political leaders more powerful to make a nexus with the medics. Donor involvement in NHP 2006 formulation process was insignificant as they were left out of the policy process, even though the execution of their policy ideas sustained through the introduction of HNPSP.

3.5.2 Heath Policy Draft in the Care Taker Regime:

Caretaker government formed in 2007 decided to update NHP 2000 and the process began in August 2008. A draft was prepared in October of the same year as eight years have passed since the last health policy was adopted. Since then, important changes in epidemiological, environmental, socio-economic and demographic fields has taken place necessitating a contextual update of the NHP. And this time in the policy making attempt, the government's objective was not just to prepare another health policy but to revise the existing one that would be accepted by all concerned.

Lesson learnt from past policy of the difficulty to get the support of various stakeholders, the caretaker government decided to construct a document that would be accepted by all groups regardless of political parties. This caretaker government further assumed that it was in a better position, than a politically elected, democratic government, to avoid the complex politics of the policy actors. To ensure everyone's support and accommodate the interests of all involved, it was a strategic attempt on the part of policy planners to keep the policy objectives in broader viewpoint. NHP 2008 therefore, omitted any talk about of contentious issues, such as unification and community clinics, from the document. It was decided that precise strategies and policy guiding principle should be dealt with in the operational plan and elaborated at later stage. NHP 2008 was primed by a nonparty caretaker government and therefore, the document did not have much authority. Support for the policy process came primarily from bureaucrats. Policy actors who objected to NHP 2008 included the civil society and medical professionals and the role of political leaders and donors in the process was inconsequential (BHW, 2010).

The review effort was led and initiated by bureaucrats in MOHFW. And the revision was not demanded by the sector but rose from the compassionate repressive decision of the bureaucrats, who felt that the process could be completed within a short period of time. The

initiative to formulate NHP 2008 came from the Health and Family Planning Advisor to the MOHFW, who on the occasion of the World Health Day on April 7, 2008[7], affirmed that the government would prepare a NHP. Later, on June 15, 2008, at a meeting held by the MOHFW, an advisory committee and a steering committee were set up for updating the health policy. Participation of political leaders was not noticeable in the policy process and their function appeared to be nearly non-existent. This could be accredited to the prohibition of all forms of overt activities of political parties during that period.

The draft NHP 2008 was robustly rejected by BMA and it took the lead in issuing press statements and holding round table conferences with various organizations. Their participation in the drafting process was not as noteworthy and there was no BMA representation in the panel of experts in the advisory committee though the Acting President of BMA was included in the steering committee. BMA provided two written observations on the NHP 2008 draft and both were about the policy formulation process and not the contents of the draft. It should be noted that the BMA as an association was mainly apprehensive about playing a vital part of the process and also questioned the authenticity of the caretaker government formulating health policy (BHW, 2010).

Civil society played a dynamic role in the preparation of NHP 2008 as it pursued more advice-giving procedure than that of 2006. Numerous discussion workshops took place where local NGO leaders participated and the draft NHP was made accessible to the general people, which facilitated deeper engagement by the civil society. As civil society member, some NGOs supported the policy as it advocated for outsourcing NGOs but at the same time, a variety of activists and civil society groups made active attempt in raising objections against the policy for hastily prepared (BHW, 2010).

3.6 Conclusion:

This chapter revealed that health system of Bangladesh has long historical past. In every regime, respective government tried to reform the community health sub-sectors according to their ideology and interest.

[7] The Daily Star ; 07 April 2009

CHAPTER FOUR

Problem Streams

4.1 Introduction:

Policy making poses several difficulties to the decision makers, apparently which do not get similar kind of attention from them. To shape the agenda, the most important task to get done with is agreeing on how to weigh the competing difficulties. Most of the cases have shown that issues backed by proper authority and channel get more policy priority. This chapter will highlight the process under which community health is given priority over several other competing issues.

Preventive vs curative care, primary-secondary-tertiary level health care, centre based urban health services vs community based rural health services, behavior change communication or health infrastructure, communicable diseases or non-communicable diseases – these are some of the dimensions that encompass the health sector of Bangladesh. Health sector reform is also an issue in the country – in fact, this is a continuing debate and phenomena of contemporary Bangladesh. Since its independence, governments have spent years trying to reform and improve the health sector of Bangladesh. Following section attempts to discuss how community health received policy priority over other competing issues in the 2010 Health Policy of Bangladesh.

Demand of an updated health policy is not new in Bangladesh. Since its independence (1971) successive every government has tried to come up with a comprehensive health policy for Bangladesh. After a long time from independence Awami League[8] Government (1996-2001) formulated a national health policy 2000. In the meantime, due to different national and international factors, a lot of changes have been made to the health situation of the country. Therefore, stakeholders of this sector have long been calling for an updated health policy. In spite of several attempts made by different political government, no initiatives were successfully carried out. According to the maximum respondents of the study, this policy formulation process goes back to the term of interim Care Taker Government[9] (2008). The

[8] One of the major political parties of Bangladesh

[9] The caretaker government of Bangladesh is a form of government system in which the country is ruled by a selected government for an interim period during transition from one government to another, after the completion tenure of the former.

then Heath Advisor[10] of the Care Taker Government of Bangladesh Dr. A M M Shawkat Ali declared the formulation of new health policy within the following three months during a meeting on the World Health Day observation to provide better health services and ensure quality education in medical and dental colleges[11]. After this declaration, different interest groups had tried to influence the policy makers to highlight their problems and prioritize their interests in the policy making process.

4.2 Interest Groups and Policy Issues:

According to the views presented by the study respondents, numerous problems were highlighted by different levels of organizations and individuals. More than 160 organizations and individuals have submitted written demand to the Program Support Office (PSO), HNPSP, MoHFW more prior to the preparation of the final draft. All of these demands reflected personal or professional interests. The written comments covered about 70 issues and a significant number of NGO participation was seen.

Table 4.1: Number of Issus Covered by Stakeholders before Final Draft Preparation

Indicators	Number
Number of Organizations and Individuals submitted written document before finalization of policy draft	160
Issues Covered by Individuals and Organizations	70

[Source: Official documents of PSO, MoHFW and Interview]

All the policy issues were not dominant. Weight of the problems and proper evidence and strategy to highlight the problems play important role to catch attention of the policy makers (Laraway and Jennings, 2002). Among the policy issues, following were more dominant compared to others.

[10] In the interim Care Taker Government Advisors are top most policy maker were are same as in status as minister

[11] The Daily Star (a national English daily in Bangladesh), 07 April 2008

Table 4.2: Highlighted Health Issues

Broad Head	Specific Issues
Community Health Issues	Rural Community Health vs. Urban Community Health, Primary health care vs. Heath Education, Female Friendly health center vs. home services, preventive care vs. curative care , Climate change and eco- health
Diseases	Communicable Diseases vs. Non-communicable disease
Service Providing Nature	Government as Regulator or Service Provider, Public Private Partnership or privatization
Human Resource Development	Medical Graduate vs. Health Assistant , Skill Development of Traditional Birth Attendant or Supply of New Skill birth Attendant
Type of Treatment	Only Modern Medical Science or Modern medical science with Indigenous Treatment

[Source: Official documents of PSO, MoHFW and Interview]

4.3 How Community Health Issues Get Priority:

Studies are one type of indicator that often focuses on a particular problem at a specific point in time. These studies are conducted by government agencies or nongovernmental researchers or academics and may suggest that a problematic issue necessitates government attention. However, studies are not primarily used to establish whether problems exist. Instead, problems are determined through interpretation (Kingdon, 1995 ; Cited in Laraway and Jennings, 2002). Nevertheless, policy makers and those who work closely with them, rely on indicators to "assess the magnitude of a problem and become aware of changes in the problem" (Kingdon, 1995,p. 91; Cited in Laraway and Jennings, 2002). Considering this theoretical aspect as guidance for the study, we were interested to know that how community health issues were highlighted by the policy advocates. Most of the respondents viewed that PSO, HNPSP, MoHFW did the ground work to prepare the draft health policy. Team Leader of PSO, HNPSP, MoHFW informed that the entire health sector of Bangladesh is visible to us and we know which problem/s need special attention for ensuring the health rights at all levels. To make the policy strategy justifiable and valid PSO, HNPSP, MoHFW reviewed national level findings (interview with respondents and team leader of PSO, HNPSP, MoHFW). Most of the respondents repeatedly told the name of following reports which has influenced highlighting the community health issues-

Table 4.3: Name of Evidences which have influence in Agenda Setting

Name of the Study /Reports	Authority of the Report
Bangladesh Demographic and Health Survey, 2007	National Institute of Population Research and Training (NIPORT) Dhaka, MoHFW, Bangladesh ; Mitra and Associates, Dhaka, Bangladesh Macro International, Calverton, Maryland USA
House Hold Income and Expenditure Survey, 2005	Bangladesh Bureau of Statistics, Planning Division, Ministry of Planning, Government of the People's Republic of Bangladesh
Bangladesh Urban Health Survey , 2006	National Institute of Population Research and Training (NIPORT), MEASURE Evaluation,International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), and Associates for Community and Population Research (ACPR).
Child and Mother Nutritional Survey , 2005	Bangladesh Bureau of Statistics, Planning Division, Ministry of Planning, Government of the People's Republic of Bangladesh
Multiple Indicator Cluster Survey 2006	Bangladesh Bureau of Statistics, Planning Division, Ministry of Planning, Government of the People's Republic of Bangladesh, And UNICEF
Challenges of Achieving Equity in Health of Bangladesh, The State of Health Bangladesh ,2006.	Bangladesh Health Watch (2007), James P. Grant School of Public Health, Center for Health Systems Studies, BRAC University, Bangladesh.
Health Work Force in Bangladesh : Who Constitutes the Healthcare System ? The Sate of Health Bangladesh 2007	Bangladesh Health Watch (2008), James P. Grant School of Public Health, Center for Health Systems Studies, BRAC University, Bangladesh.
How Healthy is Health Sector Governance?	Bangladesh Health Watch Report (2009), James P. Grant School of Public Health, Center for Health Systems Studies, BRAC University, Bangladesh.

[Source: Interview and Policy Content Review]

4.4 Why Community Health Issues Were More Dominant Then Other Policy Issues:

Policy actors deal with lot of policy problems during the time of policy problems. A specific problem takes place as an agenda in the process when that problem is accepted as a real problem. Diversity, extent and consequence of the problem in the life of common people were popular indicators to measure the weight of the policy problem (Dery, 2000). In every health system there are Community Health Status Indicators[12] (CHSI), for providing an overview of key health indicators to local communities and to encourage dialogue about actions that can be taken to improve a community's health. In Bangladesh, MDGs are taken as benchmarks to achieve the status of community health.

Most of the respondents viewed the situation of maternal health and child health, problems of health service providers, cost of health service, health services in remote area, women

[12] http://www.communityhealth.hhs.gov/homepage.aspx?j=1, Accessed, 22.04.2010

friendly health service and HIV/AIDS issues to be the dominant factors for highlighting the community health issues as a problem in the agenda setting process of health service (Source: Interview).

Following discussion will provide a description the situation of above mentioned factors-

4.4.1 Maternal Health:

Maternal health situation is one of the important indicators of achieving MDG-4. Antenatal care, place of delivery and postnatal cares are important aspects for maternal health successes. Different research highlighted maternal health issues and following discussion will cite and explain these examples.

4.4.1 .1 Antenatal Care:

Presently the antenatal care[13] from a qualified contributor who has a medical training has increased to 52 percent. There are disparities in urban – rural settings in antenatal care. 71 percent of mothers are getting antenatal care in urban region while it is only 46 percent in rural the areas. The place where a woman receives antenatal care is also of great importance because it influences the frequency and quality of antenatal care received. It also helps policymakers to decide how to allocate resources. The public sector is the leading source for ANC (44 percent), followed by the private sector (37 percent) and the NGO sector (16 percent). Approximately 12 percent of women received ANC at home (BDHS, 2007).

Causes for not taking antenatal care are another important factors for policy agenda. About 72 percent of mothers stated that check-up for antenatal care was not required, another one in four considered it to be costly, 7 percent were not aware about the necessity of the care, 5 percent of mother were not permitted to move from house for getting the services, 4 percent stated about the distance of the service from their places as an obstacle while the other 3 percent did not go outside of their homes for religious beliefs (BDHS, 2007).

National level research findings (BDHS, 2007) shows that 15 percent of births in Bangladesh take place at a health facility, about half in the public sector and half in the private/NGO sector. Women in urban areas are three times as likely as women in rural areas to give birth in a health facility. Women from the top wealth quintile are almost ten times more likely to deliver at a health facility than women in the bottom quintile.

[13] Medical care before delivery

4.4.1.2 Postnatal Care

Postnatal checkups offer an opportunity to evaluate and take care for delivery complications and to guide the mothers about how they will take care of themselves and their children. In 24 hours after the delivery, a large portion of maternal and neonatal deaths take place. Post natal care is an essential part for keeping the motherhood risk-free. Findings of BDHS, 2007 shows that 21 percent women (age from 15 to 49) received postnatal care from the qualified contributor who has a medical certificate. The women, who are going to be a mother for the first time, living in urban region (13.3 urban women and 5.5 rural women take services from public sector in the time of after delivery), fulfilled the secondary or higher education, women who are the top wealth quintile, they are more likely to get the postnatal care from the skilled contributor, who has obtained the medical training.

4.4.2 Child Heath:

Monitoring progress towards MDG 4: "reduce child mortality" is another important aspect for achieving ultimate target within 2015. The Infant Mortality Rate (IMR) is estimated at 45 per 1,000 live births, while the U5MR is around 67 per 1,000 live births (MICS, 2009). . If Bangladesh can maintain this trend, it will meet the final target well before 2015 in the term of national rate. Nevertheless, it is not high time to be satisfied, because there are, however, distinct regional variations that need to be addressed. Rural areas (according to MICS 2009 report, U5MR in rural and urban area's are respectively 70 and 58), urban slums, the Chittagong Hill Tracts (CHTs), coastal belt regions and other ecologically vulnerable areas are falling far behind. The government and its development partners must ensure that its efforts reach all Bangladeshi inhabitants.

4.4.3 HIV/AIDS Related Issues:

Meeting at the United Nations Millennium Summit in September 2000, world leaders agreed a farsighted declaration to meet the needs of the world's poorest people. That declaration gave birth to eight goals to be achieved by 2015. Reduction of HIV/AIDs is of these goals. Bangladesh is also, committed to reduce the HIV/AIDs vulnerability in Bangladesh. The report from BDHS 2007 illustrate that the women and men from aged 15-49 and who got married have knowledge about AIDS from the background characteristics. The awareness of HIV/AIDS is higher among the younger women and the married women compared to other women. The gap in awareness is much higher in rural area. Urban women are more

knowledgeable than their rural counterpart. The percentage is 87 in urban and 62 in rural area (BDHS, 2007).

4.4.4 Women Friendly Health Service:

Basic human right by international conference declarations and legal instruments stated woman's rights to be timely, affordable, and good quality health care[14] . Recently MDG also highlights the gender rights and women empowerment. In this connection, it can be said that gender friendly health services is the right of all levels of women in Bangladesh.

BDHS 2007 illustrates that the maternal health services are being difficult because the service centers are located at a distance place. On many occasions, women are not allowed to move to that distance to avail the services and also the religious beliefs pose major obstacle. The Women Friendly Health Initiatives (WFHI) has been developed with the help of the Government and the UNICEF through the participation of health professionals like obstetricians, forensic pathologists, paramedics, emergency doctors, psychologists and nurses and also the participation of lawyers, magistrates and judges, civil society organizations, media professionals, health and public sector administrators people's representatives, and development partners (CPD, 2003).

Above mentioned discussion depicts that the status of Community Health Indicators based on MDGs, are not satisfactory in term of neither equality nor equity. There are disparities between urban and rural settings as well as among the different socio-economic classes. These gaps are led by absenteeism, high cost of the health services and unbalanced distribution of health care providers. Following discussion highlights these issues:

4.4.5 Problems with Health Service Providers (Absenteeism):

Absenteeism is a common phenomenon in Bangladesh. Absenteeism of doctors is 40% at the UHCs and in the UHFWCs it is as high as 74% (Chowdhury and Hammer, 2004). The facilities in the rural areas is managed by one doctor only, and as such it suffers the most as it further reduces the probability of receiving health care by the people of that area. The 'Social Sector Performance Survey' of primary health and family planning in 2005 shows similar patterns of absenteeism (SSPS 2005).

[14] Women-friendly health services Experiences in maternal care, Report of a WHO/UNICEF/UNFPA Workshop Mexico City 26-28 January, 1999,
www.unicef.org/health/files/womenfriendlyhealthservices.pdf ,accessed 12.05. 2010

4.4.5 Health Service Expenditure:

Health service expenditure is an important aspect that determines health seeking behavior. When people fails to afford the high fees that the MBBS doctors charge, they seek assistance of the village doctors (drug sellers at pharmacy/RMP) or homoeopaths, as these options saved them the high charges of consultation fees except the cost of the medicines. A mother from Chakaria remarked, *'First I took my child to a homoeopathic doctor. Though it cost me only 15 Taka, she did not get well. Then I took her to an NGO clinic. The cost is a bit high there. But I cannot kill my child fearing for the high expense, can I?'* The whole process of treating the child cost her Tk 400. (BHW, 2008)

4.4.6 Density of Healthcare Providers:

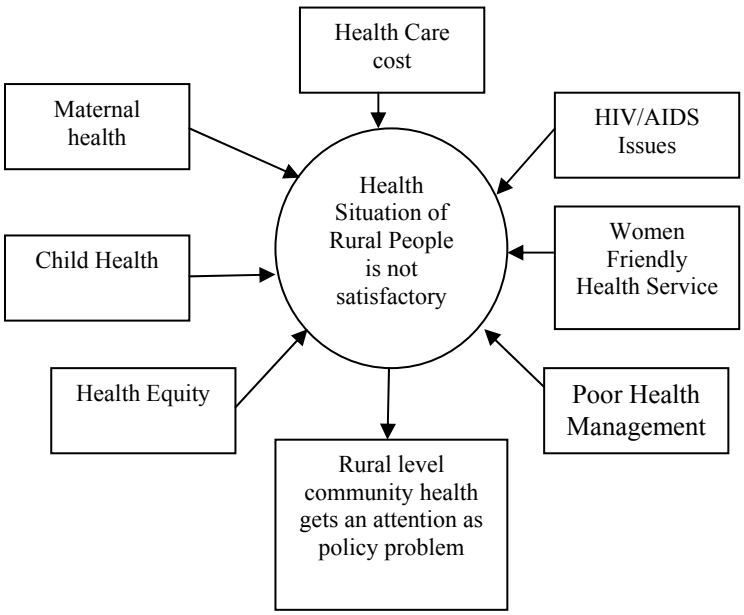
Need based distribution of human resources is the pre-condition for ensuring the health rights of people in all levels. In this connection, actors of health sectors created evidence on distribution of health care providers. On an average the study documented 146 providers per 10,000 population or almost 15 per 1,000 populations. However, one needs to be cautious in interpreting this figure. This includes all types of health providers as reported by the community people. Qualified modern practitioners including physicians, dentists and nurses have a density of 7.7 per 10,000 populations. The largest group is the Traditional healers who include *Kabiraj, totka*, herbalist and faith healers and have a density of 64.2 per 10,000 population Next in order are the traditional birth attendants (trained and untrained) who have a density of 33.2 per 10,000 population, village doctors and rural medical practitioners who mostly practice allopathic system of medicine have a density of 12.5 per 10,000 population. Sellers of allopathic medicine from drug stores have a density of 11.4 and community health workers who are mostly trained by NGOs and practice allopathic system have a density of 9.6 per 10,000 population.

Rural areas have a much higher density (170 per 10,000 population) than urban areas (81 per 10,000 population) when all types of providers are considered. There is also a huge urban-rural difference in the presence of different provider groups. Only 16% of the total qualified physicians are residents of rural areas, whereas 84% of CHWs are found in rural areas. In fact, the majority of qualified providers in addition to the physicians, such as nurses, dentists, technicians etc. practice in urban areas.

4.5 Rural Community Health Issues were highlighted by Evidence:

The above mentioned discussion revealed that the antenatal care service scenario in Bangladesh is not good in rural areas. Similarly, a large number of women from the lower quintal family were out of antenatal, postnatal care and safe delivery services. As well as, children's health situations were the worst in the rural disadvantaged areas. Also, need of gender friendly health services were highlighted by different evidences. HIV/AIDS is one of the highlighted issues in health sector. Research findings showed that awareness in the health services were not similar in rural and urban areas. There were also differences in knowledge about HIV/AIDS among the women. Not only MDG issues, also, health management issues were highlighted by the recent research findings. These findings supported that absenteeism, imbalance in human resource distribution and the high expense of medical services made the rural health situation vulnerable. It can be summarized that evidences about community health indicators and health management issues highlighted the rural community health as a policy agenda (See: Following figure).

Figure 4.1: Behind Causes for Highlighting the Rural Community Health Problems



4.6 Evidence Creation and Policy Actors:

The above mentioned discussion revealed that both government and non-government actors create evidence to highlight the health situation of Bangladesh. In this evidence creation, donor community played vital role in the following ways (For detailed activities of donors see Annex-1 and Annex-2).

Table 4.4: Donors' Strategy in the Time of Evidence Creation

Role	Strategy
Involvement of International Experts (Organization/Individual)	To ensure the quality of evidence, donors imposed a condition to involve the international experts (organization or individual) who played dominant role in setting up study indicators and methodology finalization which ultimately influence the study findings.
Involvement of Experts from NGOs	Donors played positive role to involve the experts from the NGOs sector. Here their argument is that GO-NGO collaboration or Public Private Partnership (PPP) can help to attain the desired goal.
Feedback taking and evidence dissemination	In evidence creation donors get feedback from stakeholders and in these programs policy level actors were invited by the donors as guests or chief guests.

(Source: Interview with Respondents)

In policy level evidence creation, government bureaucrats, especially people with medical education background played important role. They have vast experience and expertise about the health sectors in Bangladesh. Due to the procurement system of evidence creation and nature of health sectors (sector wide approach and HNPSP pool fund) government health experts are guided by a group of experts who are basically public health specialists (Interview with Ex-Director, Primary Health, Directorate of Health, MoHFW, Bangladesh). We observed different BDHS reports and found that professionals from different INGOs, donor agencies and national NGOs are members of these study teams.

NGOs are coming forward as vital policy actors in Bangladesh (Rabbani, 2009). In this connection, they create evidence to promote community health issues as candidate for government action. In this connection, they took some strategies to highlight their preferable issues. According to the views of the respondents of the study, NGOs takes following strategies for promoting the community health issues:

Table 4.5: NGOs Strategies in the Time of Evidence Creation

Theme	Strategy
Vision Highlighted	In deferent forum and media NGOs/CSOs highlighted their mission whose main theme is to do something for the betterment of poor and disadvantaged people. By using this statement, NGOs try to advocate for highlighting the community health issues.
Involvement of government bureaucrats	NGOs ensured participation of top level bureaucrats from NIPORT, NIPSOM, BSMMU in evidence creation and ensured the participation of government counterparts who helped in the time of advocacy.
Involvement of Elite people	NGOs offered key positions to the elite people in health sector who have good access to the policy level people.
Involvement of Media People	NGOs made collaboration media people to disseminate the evidence to their policy community[15]
Personal Communication	Both respondents from policy makers and advocacy group said that NGO advocates used personal relationship and work relationship to promote community health issues. For example, Team Leader, PSO, HNPSP, MoHFW said that senior professors and top management of NGOs talked with him over the telephone to highlight the community health issues.

(Source: Interview with respondents)

For the sake of in-depth probing, we investigated the reports of Bangladesh Health Watch[16] and found that they ensured the involvement of national professors, country directors of different INGOs, leading researchers and leaders from the media community to mobilize the policy community in health sector (For details see ,Annex-5) . For in-depth investigation we observed latest report of Bangladesh and found that following group of people were involved in evidence creation:

Table 4.6: Group of People Involved in BHW's Evidence Creation

Types of Participants	Number/s
BRAC and Its Affiliated Organizations	18
ICDDR,B	7
Representatives from INGO	4
Representatives from Public[17] Universities and Private Universities (As academician-without BRAC Universities)	7
Representative from National NGOs (Without BRAC)	7
Government Officials	2
Retired Government Officials	4
Media	1
Foreign Experts	2
Representatives from Donor Agencies	2
Representative from Local NGOs	1
Representatives from Private Hospitals	2

(Source: Prepared from BHW, 2010)

[15] A wide range of policy actors who are directly or indirectly involved in particular policy
[16] A professional body formatted by the BRAC University School of Public Health
[17] Financed by the GOB

4.7 Role of Different Actors to Highlight the Community Health Issues

To highlight the community health issues, government bureaucrats, ex-bureaucrats and NGOs played their role from their positions. For example, Professor Dr. Md. Abul Faiz, Director General[18], DGHS, MoHFW have published an article, titled, 'Need of Health Research Policy in Bangladesh' in the Daily Star, on 17th February, 2008, where community health issues were highlighted with a proper attention. Also, actors' CSOs were more vocal to highlight the community health issues. CSOs have arranged different seminars to demonstrate the stakeholders' views. In the following table we have discussed some major events.

Table 4.7: Demand Raising Activities by the Advocacy Groups

Name of the Seminar	Theme	Arranged by
'National Health and Drug Policy' (25.07.2008)[19]	Stressed the need for health policy to bring the people under a co-ordinate and caretaker government should not go for formulating a new health policy as it is not a political government.	Bangladesh Association of Pharmaceutical Industries
National Health Policy 2008 : A Critique and Plan of Action[20]	Demand for National Pro-poor Health Policy formulation and to ensure the health right in grass root level	Health Movement, A Network of Organizations to Protect Health Rights
National Health Policy and Present Context 2008[21]	BMA suggested the caretaker government to handover the policy making activities to the upcoming political government, because they are well known about the community issues	Bangladesh Medical Associations
Comments on National Heath Policy 2009	Highlights the need of people friendly health policy	Health Rights Movement, National Committee
Health Budget 2009-10 : Allocation and Utilization (14-07-2009)[22]	Demand for proper allocation and utilization of resources for ensuring the heath rights of common people. In here, interest groups and policy makers repeatedly highlights the Importance of Community Clinics	Health 21 and The Daily Star
'National health policy: Women's health perspective[23] [17 August 2009]	Frame gender-sensitive health policy	Bangladesh Mahila Parishad (BMP)

[18] A Policy level position in DGHS, MoHFW
[19] Source : The Daily Star, 26 July 2008
[20] Source : The Daily Star, 23 September 2008
[21] Source : The Daily Star, 13 September 2008
[22] Source : The Daily Star, 15 July 2009
[23] Source : The Daily Star, 19 August 2009

Name of the Seminar	Theme	Arranged by
Community Clinics : Effects on Our Health Services (12 September, 2009)[24]	To make the community clinic functional for ensuring basic health Services for the Grassroots people.	Health 21 and The Daily Star
World Rural Women's Day 2009 observed[25] [15 October 2009]	'Claim your rights to health and well-being' was the main theme and Speakers at the seminar demanded appointment of female doctors in all community clinics as the rural women have some prejudices against the male doctors.	National committee to observe the day
Climate Change : The biggest health threat coming out way[26]	Try to establish relationship between community health and disasters	Health 21 and The Daily Star

For the sake of in-depth investigation we found that these civil society groups are not permanent organization. These organizations were formed with representatives from INGOs, Donor Community, BMA and NGOs.

4.8 Conclusion:

Both GO and NGOs have influence in evidence creation. This evidence proves that, the health situation of community people are not good considering the Community Health Indicators. In the evidence creation and highlighting the evidence, NGOs are dominant and they are backed by the donor community. In the evidence creation and dissemination, CSOs were formed by NGOs representatives and representatives from donor community. To highlight the community health issues, NGOs ensured the major stakeholders' participation, and, by using these strategy interest groups, pushed the community health issues as policy agenda.

[24] Source : The Daily Star, 16 September 2009
[25] Source : The Daily Star, 16 October 2009
[26] Source : Documents Collected from Health 21

CHAPTER FIVE

Proposal Stream

5.1 Introduction:

Consistent with Kingdon's model, more than one solutions emerged for addressing a high visibility problem. Both proponent and opponent of the agenda come with different types of solutions. Considering the policy solutions, policy coherence and viability of these solutions in the specific context policy actors take decisions (Stout and Stevens, 2000). In agenda setting of health policy Bangladesh community health situation is a high lighted problem. To solve this problem different policy actors come forward with different solutions. In this chapter we discussed how proposal or proposal recognized by the policy decision makers.

Since 2008 different types of actors, especially the stakeholders of health sectors are very active to promote their policy solutions. We asked the respondent about different solutions which were proposed by the deferent policy actors. Following table will give a description of proposed solution:

Table 5.1: Dominant Proposals from Different Actors

Broad Head	Main Theme
Community Clinic	Maintenance of Community Clinic with Public Private Partnership
Health Education	Providing education through mass media and mass campaign
Door to door Service	Door to door to services through community health workers
Creation of semi-skilled manpower	Training of community or traditional manpower
Incentive for Medical professional	Extra incentives will be paid to these medical professional who are working in remote areas
Use of alternative indigenous treatment along with modern medical treatment	Medical treatment will be provided complemented by indigenous medicine
Skill development of unskilled or semi-skilled practitioners	Give emphases on quality training of unskilled or semiskilled medical professional
Mobile medical services	

(Interview with policy actors and Content of Written documents)

Among the policy solution community clinic agenda's got priority to ensure the health right of the community people of Bangladesh. Respondent of the study tried to explore the causes why community clinic issues get priority as solution. Following table will give the behind cases to promote the policy solution:

Table 5.2: Behind Cases to Promote the Policy Solution

Behind cases to promote the policy solution	Supported by the Respondent (Percent)	
	Yes	No
To provide quality service to the community people	60	40
Internationals Policy Coherence	70	30
National Policy Coherence	60	40
Feasibility of the proposal	75	25
Positive Attitude of Donor	80	20
Pressure from the NGOs	60	40
Interest of the Political party (Chance to handle the big money and personnel recruitment)	65	35

(Interview with the respondent)

Our previous discussion (chapter-4) described the situation of policy problems. The following discussion would like to describe the international and national policy coherence, feasibility of the proposal (with national and international successful example), positive attitude of donor and strategy of NGOs.

One of the Ex-Director, DGHS, MoHFW told that government was committed to national and international declarations or standard. So, government must be compliance with these national and international commitments (Source: Interview). For in-depth probing we analyzed these policy documents. We found that these documents recognized the right of grassroots people. Also, advocacy groups and stakeholders raised their voice to compliance with these declarations. Moreover, government's national and international commitments were highlighted in drafts (published on 04 July 2009) and final drafts of health policy of Bangladesh (MoHFW, 2009 & MoHFW, 2010). Following discussion gave a brief discussion of these policy coherences.

5.2 Policy Coherences:

5.2. 1 International Policies:

The Bangladeshi government is obliged to improve the status of health under several international treaties and national laws and standards. ***The Declaration of Alma-Ata*** of "health for all" in 1978 highlighted need for social and economic inputs to improve the health

of the population. Following table will describe the important clauses of Alma- Ata Declaration and main themes. Potential state actors and non-state actors raised their voice to compliance with their demand to compliance with the commitment of The Declaration of Alma-Ata (Husain, 2008 and Rahman 2006)

The Ottawa Charter for Health Promotion in 1986 further embraced the need for social and economic inputs to improve the health of the population. The Universal Declaration of Human Rights (UDHR) of 1948 and the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1966 further enunciate the appropriateness of health and human rights for the well being of individuals and the family. So there is profound affiliation between human rights and health. Bangladesh is a signatory to most of the international treaties, declarations and ratified covenants to ensure the 'right to development' as a means of promotion of human rights. It also ratified the ICCPR and ICESCR (Rahman 2006).Bangladesh is a signatory of International Conference on Population and Development, Womens' Conference in Beijing and most recently the UN special session on Children's Rights and other important international declarations. (Rahman 2006).

There are several other laws related to the regulation of health services, as well as promoting the rights of women, but none of these provide legal recourse in cases of negligence. All the declarations suggested to respective government to ensure the health and basic rights to all level people.

5.2.2 MGDs and Health Policy:

Bangladesh signed United Nations Millennium Development Goals which emphasized the community issues of maternal and child health of Bangladesh After a long conversation, on April 1 and 2, 2008, The United Nations General Assembly agreed that "Millennium Development Goals are achievable if we act now. Out of the 8 goals of MDGs, three -- reduction of maternal mortality, improvement of maternal health and combating HIV/AIDS, malaria and other diseases -- are directly related to health policy. There are another three goals which are very closely connected with the health service delivery system. They are eradication of extreme poverty and hunger, achievement of universal primary education and promotion of gender equity and empowerment of women. Moreover, environmental sustainability and global partnership for development are also related to the implementation of health policy. In fact, health poverty is no less serious an issue than income poverty. A good health policy can strengthen the progress of the nation, and make the people less

vulnerable to disease and infirmity (GOB, 2005). Demand to achieve MDGs is a popular advocacy point for the advocacy groups (Rahman 2006 and Nath 2008). Different government and non-government actors shouted that without ensuring the health rights of grassroots people achievement of MDGs will remain a day dream only. For example, Eminence, a research organization in Bangladesh arranged an advocacy program entitled with, 'Get on Track' with collaboration with Save the Children-UK[27] which main theme was to mobilize the stakeholders including media to create pressure on government to ensure the health rights of grassroots people (The Daily Star, 07 September 2008.).

5.2.3 Poverty Reduction Strategy Paper (PRSP)

PRSP Strategic Block IV includes children's health, maternal and Reproductive health, women's general health, adolescent health, communicable diseases, Non-communicable Diseases, drug sector, alternative medical care (AMC), Nutrition, health governance, NGO Sector, health finance, food safety, water and sanitation. From this we can realize that PRSP also emphasis on the health service (GOB, 2005.a).

5.2.4 Constitution of Bangladesh:

According to the constitution of Bangladesh "it shall be a fundamental responsibility of the state to attain, through planned economic growth, a constant increase in productive forces and a steady improvement in the material and cultural standard of living of the people with a view to securing to its citizens (a) the provision of the basic necessities to life, including food, clothing, shelter, education and medical care" [35], Article 15]. Article 16 of the constitution also mentions that the state shall adopt effective measures to reduce disparity in health care progressively. Article 18.1 also depicts that the state shall foster rising levels of nutrition and the improvement of public health measures and Article 19 gives importance towards reducing inequality. Bangladesh has given high priority to the development of social sector including health and education with high level of political support. The constitutional provision also guaranteed employment with reasonable wage, right to social security, and quality of life [35], Article 15, 16, 18, & 19]. The constitutional provisions are made to protect, promote and respect health care as a constituent of human rights in Bangladesh. [Source: Constitution of Bangladesh].

[27] An International Non-government Organization working in Bangladesh

5.3 Success Example

In agenda setting good examples, models and lesson learned from national and international context are the dominant factors to vitalize policy issue as an option for policy decision making. Success examples and lesson learned from non-government sectors as well as success examples from India and Uganda played important role for considering community clinic as proposal for solving health problems of community people (Interviews with the respondents). In this regard, Team Leader of PSO, HNPSP, MoHFW mentioned that this policy document was very much influenced by lesson learned from different programs , like as Past Experience of HPSP, Community based intervention of NSDP, UPHCP and BRAC's health program'. The following section described the main features of success examples. For in-depth probing we analyzed nature of these programs.

5.3.1 BRAC Community Health Program:

BRAC, a home-grown Bangladeshi NGO (for more information, please visit http://www.brac.net) realizes the vulnerability of the poor households. Towards this end, it integrates Essential Health Care (EHC) services in its micro-credit and education program. Since it's inception in 1972, BRAC has been the major producers and promoters of Community Health Workers. The front-line worker of BRAC's health program is the *Shasthya Sebika*, SS (meaning a woman who provides basic healthcare services in the community) who forms the core of its EHC services. They are trained on basic preventive, promotive and curative health care which is backed up by regular monthly refresher training. They provide a cost-effective bridge between the communities they serve and the primary health care (PHC) level facilities of formal Health Systems, though they are not part of it. Currently, BHP has about 70,000 SS actively providing services to about 90+ million people in the rural areas of Bangladesh (Ahmed, 2008).

Community based health intervention of BRAC is popular due to door to door services, female health service providers, cost effective services and close intervention in the community with lower formal educated but trained women. And this health service is one of the success examples and also, recognized by national and international community (Barnes, Gaile & Kimbombo 2001; Pitt, Khandker R, Chowdhury & Millimet 2003 and Nanda. 1999).

5.3.2 NGO Service Delivery Program (NSDP):

CHWs working in the NGOs under NSDP are titled Depot Holders. They are selected from amongst the community members. Prospective candidates for depot holders are identified

through discussion with community people. Depot Holders must have at least eight years of schooling and be married in order to be eligible for being that. Depot holders sell pills and condoms, oral saline and some over the counter drugs. In addition to selling these products they encourage and motivate people to perceive health services from satellite clinics and static clinics. Besides, they provide information on the sources of health service. Following their recruitment, the CHWs are provided with 14 days long in-house training by their supervisors, i.e., service promoters on Essential Service Package of the government. Every moth, day long refresher training is held at the NGO clinics. Their first referral point is satellite clinics. NSDP services reached approximately 20 million people in disadvantaged rural areas and urban slums (NSDP 2007).

Main funding source of this program is USAID. USAID also played vital role in documenting the success examples of NSDP services. One of the exceptional examples of the program is involvement of corporate body in the health program. This program is good examples because it ensures the services in the community and the gender friendly strategy was in the main point of the service providing strategy.

5.3.3 Urban Primary Health Care Project (UPHCP):

Partner NGOs of UPHCP classify two types of workers they are outreach workers and service promoters. Approximately a total of six hundred service promoters and six hundred outreach workers are working under UPHCP program. Both types' workers are recruited through advertisements in the daily news papers and interview. The educational requirement of the outreach workers and service promoters amongst the NGOs of UPHCP varies. In larger NGOs the educational requirement is higher. For outreach workers is Higher Secondary Certificate (12 years of schooling) and for the smaller NGOs it is eight years of schoolings is mandatory. But service promoters with graduation are preferred by larger NGOs (BHW 2008).

Outreach workers and service promoters are provided with basic in-house training on Behavioral Change Communication (BCC) and all components of Essential Service package after recruitment. Generally they are provided with 2-3 day long in-house refresher training once in two years. The work of both outreach workers and service promoters are supervised by the Field Supervisors. Field supervisors make surprise visits at the field level. Outreach workers maintain follow-up registers. Field supervisors randomly check the follow-up registers and verify information of the follw-up registers. Their performance is assessed on

the basis of client's turn over at the respective satellite clinics, their behavior with the clients and their knowledge on the subjects on which they had been provided training (BHW 2008).

Abovementioned discussion revealed that success examples are created by NGOs. These were treated as success examples due to low cost and community based service nature. Also, these services were women friendly and pro-poor. Not only national examples there were some international success example.

5.4 International Examples:

Always community driven initiatives bring more success that any other services. Community based services give easy access to the all level people. Furthermore, women and disadvantaged people get special befit from the community based services. In the agenda setting on community health of Bangladesh is influenced by following examples.

5.4.1 Example from India[28]:

More than 23,000 Primary Health Centers across India are managing by public private partnership. This is a unique model because of quality healthcare at an affordable cost to those in the villages. These services reached huge number of community people. Among the community people maximum were women and disadvantaged people. Considering these positive factors, health right activist and community people are raising their voice to scale this program.

5.4.2Example from Uganda[29]:

In Uganda national and international organizations are providing community based services. In collaboration with Save the Children USA and the Uganda Ministry of Health, Family Health International (FHI) conducted a cohort study which demonstrates the safety, feasibility, and acceptability of community-based distribution (CBD) of medicine (DMPA or Depo-Provera) in a rural Ugandan district.

5.5 Conclusion:

The above mentioned findings depicted that both state actors and non-state actors have taken initiatives to highlight the community health problems. The issue got priority as agenda for decision because international and national commitments, socio-economic viability and some success example acted as positive factors for highlighting the proposal.

[28] http://www.gereports.com/taking-healthymagination-to-community-clinics-in-india /
[29] http://www.usaid.gov/our_work/global_health/pop/techareas/repositioning/cbd_depo.pdf

CHAPTER SIX

Politics Stream

6.1 Introduction:

According to Garbage Can Model third stream of agenda setting is political stream. This stream considers the factors in the political environment that have a powerful influence on the agenda setting. Kingdon identified three major components that make up the political stream: the national mood, organized political forces, and events within the government (Laraway and Jennings 2002). In this chapter we would like to discuss how political parties play the role in agenda setting of community health.

Public policy is the result of interactions and dynamics among actors, interests, institutions, and processes. The formation of policy agendas political factors played important role. In a variety of beliefs and ideology are found in a political system in general. It is important for to understand how these beliefs and ideologies are shaped in policy making. Also, differences in political ideologies and beliefs have consequences in public policies. In parliamentary system of government political parties formulate government and government takes policies. Furthermore, the political roles played by a variety of lobbying and interest groups. They mobilize the community people. Understanding the ways in which political culture affects and informs political participation will be the main concern of the following discussion.

6.2 Health Strategy of Different Political Parties:

Since the introduction of Primary Health Care (PHC) in Bangladesh during the past three decades three major political parties ruled the country. Every government lasted for 5 years or more each time. None of the two major parties could retain power for two consecutive terms and thus could not continue their policy for long time. In spite of the frequent changes in the government, international commitment for PHC through Health for All (HFA) by the year 2000 and the achievement of MDGs by the year 2015 is carried on. All the ruling parties took PHC as one of the priority sector for national development and carried on various programs for achieving HFA[30] .

In general, the policy priority of all the political parties is to ensure ‘health for all. Although broadly the policy priority of each political party is same, strategically they differ. Always Awami League gives preference to established community level health facilities. In the first

[30] www.searo.who.int/LinkFiles/Conference_Ban-15-Jul.pdf

general election held in 1973, Awami League pledge to accelerate family planning programs and establishes rural health centers. These commitments of AL have been reflected in the First Five Year Plan (1973-1978). With this objective, the First Five Year Plan (1973–78) adopted the strategy of establishing the health infrastructure along with capacity building of health professionals. Accordingly, the construction of health centres at the union level and health complexes (31 bedded hospitals) at the *thana* (sub-district) level began (Osman , 2004 & Osman , 2008). At first stage BNP Government were more explicit about urban hospital based care. Although in the 1979 election, BNG give priority to preventive care and rural health, in 1996 election, it gave priority to curative care (Osman, 2004).

In 1977 the government felt the need for private sector participation in health service delivery which was reflected in the interim Two Year Plan (1978–80) and in the Second Five Year Plan (1980–85). The Plan encouraged the private sector and NGOs to share some responsibilities for providing healthcare services to the bulk of the population. As a result, private healthcare facilities started increasing rapidly after 1982 when government restrictions on private laboratories, clinics and hospitals were relaxed (Khan 1996) and some vertical program started to be implemented through public-private-NGO partnership. The Second Plan specified its focus on 'primary healthcare' as a means of providing 'minimum healthcare' to all and continued emphasis on the construction of health infrastructure to achieve this goal. The Third Five Year Plan (1985–90) added a new dimension in health services by focusing on Maternal and Child Health (MCH) as an effective means of population control. Accordingly, some MCH program like Expanded Program on Immunization (EPI), Vitamin 'A' distribution and control of diarrhoea were intensified. The Fourth Five Year Plan (1990–95) also emphasized MCH services along with a focus on primary healthcare. The Fifth Five Year Plan (1997–2002) added certain new strategic issues under the influence of the Health and Population Sector Strategy (HPSS) adopted in 1997.

6.3 Politics among the Political Parties about Community Clinic:

AL government has established participatory health institution at the village level for providing opportunities for more inclusive forms of representation, to bolster community acceptance and to create real pressure on community level staff. Behind the 'people-centered' Alma-Ata Declaration in 1978 lies an assumption that community participation in decisions about local health services will lead to better health outcomes[31]. In 1998, as part of health

[31] http://www.participedia.net/wiki/CommunityManaged_Clinics_and_Health_Watch_Committees_in_Bangladesh

sector reforms, the Bangladesh government attempted to enhance community participation in the public health system. Two experimental initiatives sought to bring about more 'people-centred' public health provisioning. In one initiative the Ministry of Health and Family Welfare set up community-owned and managed health clinics in every village or ward. The community-run clinics were mobilized by the *Union Parishad* [32], an elected local administrative body. Nine councilors would comprise a committee composed of local representatives, local service providers, influential residents and landless people's representatives. This group would be responsible for the operation of the clinic.

In this connection 11,159 community clinic were already built during 1999-2001 to provide ESP services to the rural poor but by 2004 recorded, "85 per cent of these community clinics had remained unused for the last three years allegedly for being constructed during the AL rule" (Daily Star, 29 April, 2004). Clearly the new government did not find the community clinics of such value. It was argued that

> "Community clinics were considered to be ineffective and an enormous financial burden, which was getting increasingly difficult for the government to maintain. Our key concern was that community clinics would further expand the role and influence of doctors in the health sector, when it was critical to increase the supply and capacity of other important service providers in the health systems such as nurses, medical technicians, administrators, financial experts and so forth" (Cited in BHW 2010).

The reservations of BNP government over the community clinics program, as stated by previous study were as follows:

- The FP staff is the core workforce in Bangladesh's health service who remains in close contact with the people through their door-to-door services. By offering one-stop service points, community clinics threatened to limit door-to-door service provision, thereby weakening field level activities and reducing government's contact with the people.
- the clinics were built on land donated by the community, and the sites were not always easily accessible. the government was not clear in its strategy on how the clinics would be managed since there was a chronic absence of staff, basic medical supplies, etc. While there was demand for the clinics, this was based on very different

[32] Last tire of local government in Bangladesh

expectations of the local communities, who assumed that doctors and medicine would be available on a regular basis. Low government budget (only Taka two lakhs) also meant that the clinics were of poor quality (Cited in BHW 2010).

6.4 National Mood:

Demand of general peoples, attitude of state-actors, study findings, donors attitude were very much positive to take the community clinic initiatives as solution for solving the rural health problem. Though there was littlie tension between two major political parties (BNP and AL) , they have commitment to the people for ensuring health for all (See: Previous Chapter 3, 4 and 5).

6.5 AL's Role as Political Party:

In the time of health Caretaker Government, while they were trying to formulating the policy draft then AL arranged press conference. In this conference AL's Health and Population Secretary Dr Mostafa Jalal Mohiuddin urged the caretaker government not to change the existing health policy and said it should be left to the next elected government. Also in his press conference he stressed the AL's priority to the community clinics in Bangladesh. (The Daily Star, 18 September 2008).

6.6 Present Government and Health Strategy:

According to the majority portion of respondent, the present government consists with a number of health professionals and they were very much enthusiastic to promote the community clinic issues for ensuring the health rights of community people of Bangladesh (Interview with respondents).

Also as a political party AL has commitment to the people to established the community clinic for the betterment of common people. Election Menifesto of AL in Election 2008 highlighted the community clinic in the following way –

> "In order to ensure health facilities to every citizen of the country, the health policy of the erstwhile Awami League government will be reevaluated and adjusted according to the demands of the time. In the light of this policy, 18000community clinics, established during Awami League rule, will be commissioned."
>
> [*Source: Election Manifesto of AL in Election 2008*]

6.7 Enthusiasm of Leading Political Leaders:

In any national level policy making leadership from the political parties have get influence. If top political leader of ruling party takes initiative to promote the problems or proposal then that policy that demand get priority promptly.

According to the Team leader of the PSO, HNPSP, MoHFW, Health Minister was very much interested to prepare the health policy and promote the community clinic agenda , as well as he give direction about the strategic part of the policy content. Also, health minister publicly declared about the issues of health policy. He said,

> "The government would take steps to build one community clinic in the country. The present government would also formulate a new health policy to reach health services to the doorsteps of poor" (The Daily Star; January 10, 2009).

In parliamentary government system Prime Minister is the top policy decision maker in a country. In Bangladesh dynastic characteristic is dominant in political culture. So, Prime Minister is the supreme policy decision makers in Bangladesh. She was interested about the community clinic issue. Her several commitments promote the issue as policy agenda.

Table 6.1: Prime Minister's Publicly Commitment about Community Clinic

Prime Minister Commitment	Source
Hasina pledged to reintroduce some programmes like allowances for the freedom fighters, elderly allowance, widow allowance, `asrayan' housing projects and community clinic scheme.	The Daily Star, 10- 01-2009
The prime minister said one community clinic is being set up across the country for each 6,000 people. Besides, 10,723 community clinics set up during the previous Awami League government have been reactivated.	The Daily Star ; May 5, 2010
'The prime minister said her government will set up one community clinic for every 6000 people of the country, as it wants to deliver quality medicare service to the doorsteps of rural poor'.	The Daily Star , November 1 ,2009

Conclusion: It can be said that political ideology**,** political commitment of the top leaders and positive national mood were the main factors for highlighting the policy problems and proposals as agenda for further decision making.

CHAPTER SEVEN

Discussion and Conclusion

State actors and non-state actors play their role in the policy process. During the time of agenda setting interest groups try to influence the policy makers to consider their preferable issues (Howlett and Romesh, 1995). Like other policy process, different actors and factors impacted the generation of ideas in health policy. Till today, health situation of Bangladesh is not satisfactory in term of 'equity and justice' (BDHS, 2007 & MIC 2006). In the literature of policy ownership, source of ideas/visions is treated as one of the major indicator to measure the ownership of policy (Osman, 2006). In public policy process 'agenda setting' is a stage where owner of ideas/vision and promoter of the ideas adopt different strategy to draw the attention of the policy makers. In public policy making 'ownership' can be measured with participation of different actors in policy process. In this connection role of the different actors were investigated in this study.

According to Jhon Kingdon's Garbage Can Model, an issue becomes agenda with three confluence "streams". Different actors play their role from their own perspective in these steams (Howlett and Romesh, 1995). In this study it was found that three steams emerged at the same time and opened a window. In problem stream evidence production and dissemination were highly supportive for highlighting the problems of community health issues as policy agenda. In proposal stream national and international policy coherences, international and national good practices and positive attitude of donors were among other factors that supported the community clinic issues as policy proposal. Also, political support of the ruling party (AL) was also positive to highlight the community clinic and community health issues. These problems were highlighted in different documents of governments, NGOs and donors. More over, these problems were recognized by bureaucrats, politicians, media people, donors and NGOs. Apart from evidences, ordinary people through experiences and observations also recognized these problems. Thus, all stakeholders had good faith about these evidences. It can be said that three confluence streams emerged and opened a policy window to take a decision for establishing community clinic for solving the community health problems in Bangladesh. In every stream, different actors and factors played vital role to highlight the issue.

Evidence is crucial to guide improvements in health systems and develop new initiatives. In this connection state actors and non-sate actors create evidence for highlighting the importance of a policy problem or issues. In this study effort has been made to analyze the system of evidence creation and evidence dissemination. From the systems perspective, it is important to understand how research and knowledge from various sources are produced and synthesized (Pang and et.al 2003). In addition, effort has also been made to investigate how the research findings were highlighted to strengthen the demand of good health services for community people. BDHS (2007), UHS (2006), BHW (2008, 2009, 2010), MICS (2006, 2009) etc. were main sources of evidence which highlighted the health problems of rural community. These evidences revealed that maternal health situation and services have not reached to the satisfaction level. Situation of child health is still in an alarming condition for attaining national and international goals. Till now population problem is a big challenge for development of Bangladesh but evidence showed that there are human resource gaps in community level to offer proper services to the community people. Cost of health services, absenteeism and distribution of health service providers in the community level were dominant factors which played vital role to highlight the community health situation as a problem.

It was found that about 160 organizations and individuals took part in the agenda setting process of the health policy. Among the participants, NGOs presence was significant considering their number. A one may wonder why a significant number of NGOs took part in the agenda setting process. The answer is a large number of NGOs are working in health sectors of Bangladesh whose mission is to highlight the common peoples' rights and external support for doing policy advocacy (Rahman, 2006; Haque, 2002, WB 2005). Majority of the participants' expressed their personal, organizational or professional interest. This expression is relevant in line with the rational choice theories or interest group theories.

Health professionals from government side played significant role while creating evidences. In the absence of wide ranging government sponsored research these professional remained engaged in writing articles in journals and news papers. Due to contracting system of evidence creation, bureaucrats were guided or assisted by a number of consultants and their influence are are decreasing nowadays. Apart from the findings of the present study many previous studies showed that during unification of two wings of MoHFW (family planning and health) IMED created evidence to analyze the context (Sundewall and et. Al 2006).

Research findings showed that bureaucrats who were influential during the period of 1996-2001 did not able to exert influence after 2000 (BHW, 2010 and Osman 2007). It is mentioned that successive health secretaries were either explicitly against or remained passive over the unification process and community clinic program, resulting weak bureaucratic leadership within the ministry (Osman 2005). Among the professionals who are involved with party politics, DAB (Bangladesh, aligned with the BNP) and SCP (Shawdhinata Chikitshak Parishad, aligned with the Awami League) played influential roles in agenda setting of community health issues. In this study it is found that these members who are affiliated with SCP remained vocal from the very beginning of the policy process when Health Advisor of immediate past caretaker government (2008-09) initiated the process of health policy formulation. Historical evidences showed that DAB had great influence in the agenda setting during the draft preparation in 2006 (BHW, 2010). In case of NHP 2010, SCP played an important role in community related agenda setting since they are well connected with the Prime Minister and Health Minister. Medical professionals, particularly physicians, were in favor of the implementation of major reforms under the NHP 2000. Previous researches found that support of the professionals for the two major elements of the NHP 2000 (unification and establishment of community clinics) was reflected in the policy document prepared by the Bangladesh Medical Association (BMA) (BHW, 2010).

Donors provide financial supports during evidence creation. While offering financial support, donors imposed some conditions including methodology finalization and indicators setting which ultimately, influenced the process of making evidence based policy. In addition, donors suggested government to include NGOs in this process on the ground of GO-NGO collaboration or public-private partnerships. In the community health related evidence creation USAID, UNICEF and WHO played leading role since 2000. Thus, it can be said that donors had great influence in evidence creations about community health issues. Of course, this is not new in the health sector of Bangladesh. In case of evidence creation for Sector Wide Approach introduction donor community provide guidance and financial supports for evidence creation. (Sundewall, Forsberg and Tomson, 2006) . When compared to equivalent government operations, NGO services generally run more efficiently and cheaply keeping closer ties with communities. For this reason, donors often favor them as entry points to accessing communities in Bangladesh, especially since the 1980s (Davis ,2001). In other words, NGOs become powerful and influential, especially because of their external sources

of financial support, cooperation, and advocacy. In this regards, NGOs are considered as spokesman of donors.

Civil society/NGOs are potential actors to highlight health rights and social welfare goals through mobilization of citizen demand. Through different activities NGOs emphasized on the decentralization as a means of localizing policy-making, bringing decision- making closer to disadvantaged groups, and encouraging local participation. Also NGOs are playing roles of academics and professionals by monitoring and analyzing contextual factors (Schurmann and Mahmud, 2009). In this study we found that NGOs remained more or less equivalent in the creation of evidences. Bangladesh health watch was in the leading position to provide evidence for policy making.

Bangladesh Health Watch (BWH), located at the BRAC School of Public Health, publishes a report every year focusing specific themes key indicators. The first report, published in 2006, addressed the theme of health and equity. Bangladesh Health Watch is governed by an advisory board consisting of key persons in the field of development and health. A working group carries out different activities of the Watch. BHW ensured participation of top level bureaucrats, elite people in the health sectors who have good connection with the policy makers and leaders of media community. They assumed that media can help in disseminating information and mobilizing stakeholders. They are advocating in favour of involving people from government in order to build relationship and to make the government as part of this process. Nowadays, power relationship between NGOs and government are changing. There are internal and external factors that continuously shape and change this power configuration. It has been pointed out that the government–NGO relationship, in general, may take three major forms including: formal collaboration (based on a joint mandate), formal or informal links (exchange of ideas and information), and formal or informal interaction (conflicting or supportive) (Haque, 2002). The Health, Nutrition and Population Sector Plan (HNPSP), 2003-2010 of the Ministry of Health and Family Welfare, Government of Bangladesh, notes that civil society should advocate and support the needs of the consumers (GOB, 2005 c).

Good number of health professionals are working In BRAC, it has good relation with coupled with world renowned health institutions, its health program has wide health coverage, it has future visions and good network with all sectors within the country and outside the country. These factors act as assets for creating evidence and examples. Finally, using these evidences BRAC does advocacy activities.

To highlight the community health issues people from bodies composed of medical professional, top management of NGOs and people from donor community formulated different advocacy groups. By conducting in-depth investigation, it was found that medical professionals who are affiliated with national politics, (like SCP) were in leading position to form different advocacy groups with the assistance from the people from NGOs and donor community. Overlapping in membership was found among the advocacy groups. Main causes of such overlapping lies in the fact that same people would like to push his/her preferred agenda to the policy arena. In addition, some instant advocacy groups were formed by the medical professionals to promote their policy agenda. Good connection or network among the medical professionals working in NGOs, INGOs and Donor agencies played an important role to formulate the advocacy groups. Some time they used personal relationship during advocacy, because informal relationship in Bangladesh is very active in organizational communication (Teacher student relationship, working relationship and relationship from education background).

Demand for the women friendly health services were raised by the women organizations. For instance, Bangladesh *Mahila Parisad* (Bangladesh Women Council) and *Naripakho* (Women Alliance) remained vocal than any other organizations for highlighting the women friendly health services at village level. *Bangladesh Mahila Parisad* organized seminars where top policy makers were presented as guests or chief gusset. Moreover, while celebrating World Rural Women's Day, women's organizations, specially *Karmojibi Nari* (Employed Women-a nation women's organization) pressed their demand for making appointment of women doctors in community clinics in Bangladesh (The Daily Star, 17 September 2010).

During agenda setting different policy issues came forward from different corners. Basically professional groups remained enthusiastic to promote interested areas. Professionals having background of non-communicable diseases, professionals of mental health, experts of communicable disease, NGOs, Environmental Health Experts and public health experts remained vocal about their concern issues. To demonstrate their voices they organized seminars, wrote newspaper articles and mobilized the policy community (Daily Star, 31 January 2010; The New Age, 31 December 2009; The New Age, 19 August 2009). In addition, it is found that NGOs and public health workers remained vocal about the community health issues because they are committed to do something for the betterment of disadvantaged people.

The study findings suggest that ideologically successive governments of Bangladesh are committed to provide basic health services to all. Moreover, socially and economically, operation of community clinic is reasonable in Bangladesh which can ensure well being of women and girl in the highly stigmatized society. It can also reduce the health expenditure of the rural community.

International and national policy coherence played a vital role in highlighting the community health agendas in Bangladesh. Different organizations created pressure on government to accommodate all national and international commitment in the policy. In order to highlight the community health, women health and community clinic issues, *Naripkha*[33], Eminence and Save the Children-UK conducted advocacy work so that goals of MDGs can be achieved.

From the historical perspective donors played an important role in the health sector of Bangladesh (Jahan 2003, Buse 1999). It is found in the study that members of donor community were very much positive about community clinic in Bangladesh. Green signal from the donor communities was one of the major factors that highlighted the issue. Leading donor agencies and UN bodies and WHO showed their commitment to provide support in the improvement of community clinic services (The Daily Star, 10 March 2010).

While identifying good practices, donors played a vital role by providing financial and non-financial resources. The donors helped the partners in capacity building and in mapping of success examples (See-Annex: 1). The HNPSP has been funded this time by DFID, CIDA, SIDA and EC through the pool system, and the agencies have justified the newly adopted process with a view to expediting activities of their own, paying only a little attention to the betterment of health sector of the country. We should also take into account the experiences USAID has attained while implementing NSDP as a parallel donor agency or those of ADB when it implemented UPHCP through LGRD as something helpful for the future. We should make our policy bearing in mind the relative differences and outcomes of the processes, both public and private, that were adopted while implementation the UPHCP. If only the donor agencies provide fund taking into consideration the government issues and other health related issues, then is it possible to achieve the goals of MDGs. We need to bear it in mind that even today almost 70% deliveries are conducted by unskilled attendants, 50% of the newly born children are not solely breastfed up to six months of age, NCDs are fast spreading

[33] www.humanrightsimpact.org/.../HeRWAI.../Summary_Bangladesh_WGNRR.pdf , Acessed-

in urban areas, and quality control of drugs could not be assured. And we need to place specific proposals to the donor agencies keeping all these in view.

The UN agencies deserve appreciation for their activities in Bangladesh (See-Annex; 2). UN agencies create good practices in Bangladesh. Not only national level good practices, there are international good practices as well. During agenda setting good practices from India and Ugranda played an influential role to take policy level decision about the community health issues in Bangladesh.

Politicians played an active role in the policy arena during 2001-2006 as compared to the past. The partial rejection of NHP 2000 can be attributed to the culture of confrontational politics and intolerance that permeates every level of the polity and not necessarily to the ideological differences of the political parties (BHW, 2010). A close liaison of the medical professionals (particularly physicians) with the ruling party members was the main source of power of the politicians. They were initially influenced by the bureaucrats to reverse the reform. In this study, it is found that as a political party AL made a commitment in the election manifesto of 2009 that they would set-up the community level health clinics. Moreover, top level policy makers including Prime Minister and Health minister were enthusiastic to promote the community health issues that they publicly announced.

Conclusion:

It can be said that proper evidence for highlighting the problem, stakeholders support in the solutions and strong political support highlighted the community health issues as issues to be considered in government actions. In evidence creation and conducting advocacy, NGOs who backed by the donors remained vocal. Top level bureaucrats also played their role with the help of consultants who were generally recommended by the donors. Finally, recognition of ruling political party played an important role in this regard.

References:

1. Ahmed Syed Masud (2008). Taking Healthcare where the Community is: the Story of the shasthya sebikas of BRAC in Bangladesh BRAC University Journal, vol. V, no. 1, 2008, pp. 39-45
2. Aminuzzaman, Salahuddin (2002). Public Policy Making in Bangladesh: An Overview, Public Money and Management, Vol.2, June 2002
3. Barbados Bridgetown (2007). Policy Analysis and Decision Making with Emphasis on Chronic Non-communicable Diseases: Agenda-Setting, October 15-17, 2007 , Cristina Puentes-Markides, Health Policies and Systems
4. Barnes C, Gaile G, Kimbombo R (2001).. Impact of three microfinance programs in Uganda. USAID-AIMS Paper. Washington DC: Management of Systems International; 2001.
5. BDHS (2007). National Institute of Population Research and Training (NIPORT), Mitra and Associates, and Macro International. 2009. Bangladesh Demographic and Health Survey 2007. Dhaka, Bangladesh and Calverton, Maryland, USA: National Institute of Population Research and Training, Mitra and Associates, and Macro International.
6. Berry L. Suzanne & Schmidt Joe (2001) Measuring the Impact of the Health Care Sector on a Local Economy: Sunflower County, Mississippi ; Mississippi State Department of Health, Mississippi Office of Rural Health.
7. BHW (2007). The Sate of Health in Bangladesh 2006 : Challenges of Achieving Equity in Health, Bangladesh Health Watch (BHW), BRAC University School of Public Health, Dhaka
8. BHW (2008). Bangladesh Health Watch Report 2009 : How Healthy is Health Sector Governance, Bangladesh Health Watch (BHW), BRAC University School of Public Health, Dhaka
9. BHW (2010). The Sate of Health in Bangladesh 2007 : Health Workforce in Bangladesh , Bangladesh Health Watch (BHW), BRAC University School of Public Health, Dhaka
10. Buse Kent (1999). Buse,Kent(1999)Keeping a Tight Grip in the Reins : Donor Control over Aid Coordination and. Management in Bangladesh,Health Policy and Plannnig, 14(3). 219-228
11. Chowdhury and Hammer (2004). Chaudhury, N., and J. S. Hammer. 2004. "Ghost Doctors: Absenteeism in Rural Bangladeshi Health Facilities." World Bank Economic Review 18(3).
12. CPD (2003). Health Sector Programme in Bangladesh: Promoting Participation and Gender Equity, Center for Policy Dialogue, Dhaka, Report No. 53

13. Creswell, J. W. 1994. Research Design: Qualitative and Quantitative Approaches, London: Sage Publications.

14. CSG (2008). State Policy Guide:Using Research in Public Health Policymaking : A Publication of The Council of State Governments, USA, www.healthystates.csg.org

15. Davis PR. Rethinking the welfare regime approach: the case of Bangladesh. Global Social Policy 2001;1:79-107.

16. Denzin, N. K. 1978. The Research Act: A Theoretical Introduction to Sociological Methods (2nd Ed.). New York: McGraw-Hill.

17. Dery David (2000). Agenda Setting and Problem Definition, Policy Studies, Vol. 21, No. 1, 2000

18. Feagin, J., Orum, A., & Sjoberg, G. (eds.). 1991. A Case for Case study, Chapel Hill, NC: University of North Carolina Press.

19. GOB (2005 c)Bangladesh. Ministry of Health and Family Welfare. Health Nutrition Population Sector Policy (HNPSP) 2003-2010; revised program implementation plan. Dhaka: Ministry of Health and Family Welfare, Government of Bangladesh, 2005.

20. GOB, (2005 a). MDG Progress Report, Bangladesh, Ministry of Planning, Dhaka, Bangladesh

21. Grieve H Roy (1995).“Health for All by 2000” Some issus of Health and Health Care in Bangladesh in, Grieve H Roy and Hue Mozammel (1995). Bangladesh Strategy for Development, UPL, Dhaka

22. Haque M. Shamsul (2002), The Changing Balance of Power between the Government and NGOs in Bangladesh, International Political Science Review , Vol 23, No. 4, 411–435

23. HNP (2007), The World Bank, April 2007, Bangladesh

24. Howlett M. and Romesh M. (1995), Studying Public Policy-Policy Cycles and Policy Subsystems. New Yourk ; Oxford University Press

25. Husain Zakir (2008). Thirty years after Alma Ata: time to look back and think ahead, The Daily Independent, 08 February 2008

26. Jahan R (2003). Restructuring the Health System: Experiences of Advocates for Gender Equity in Bangladesh Reproductive Health Matters, Volume 11, Issue 21, P. 183-191

27. Jahan, Rounak and Salehin, Masudus 2006. ‘Health Care for Rural People of Bangladesh: Overview of Some Governance Issues’ in Salahuddin M. Aminuzzaman eds ‘Governance and Development: Bangladesh and Regional Experiences’. Shrabon Prokashoni, Dhaka.

28. Kalu Kalu N (2005). Competing Ideals and the Public Agenda in Medicare Reform: The "Garbage Can" Model Revisited, Administration Society 2005; 37; 23

29. Kelly Branden (2005) John Kingdon's Theory at the State Level: A Look at Preschool for All in Illinois and California, www.crocus.georgetown.edu/reports/CROCUS workingpaper5.pdf , accessed 17.05.08

30. Kennedy Scott (2009) Comparing Formal and Informal Lobbying Practices in China: The Capital's Ambivalent Embrace of Capitalists, China Information 2009; 23, Sage Publication

31. Khan , M. Mahmud(996). Development of Private Health Care Facilities in Dhaka City : Impacts on Cost, Access and Quality, Paper Presented at the Center for Development Research, Dhaka, Bangladesh, 3 August

32. Laraway Alisha S. and Jennings Carole P. (2002). Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA): A Policy Analysis Using Kingdon's Policy Streams Model, POLICY POLIT NURS PRACT 2002; 3; 358

33. Maxwell, J. A. 1997. Designing a Qualitative Study. In L. Bickman., and D. J. Rog (eds.). Handbook of Applied Social Research Methods, London: Sage (69-100).

34. McGregor Sue L. T (2004). Modeling the Evolution of a Policy Network Using Network Analysis, Family and Consumer Sciences Research Journal, Vol. 32, No. 4, Sage Publication

35. MIC (2006). Multi-indicator Cluster Survey, 2006, BBS, UNICEF GOB, Dhaka

36. MICS (2009). Multi-indicator Cluster Survey, 2009, BBS, UNICEF GOB, Dhaka

37. MoHFW (2010). Final Draft of Health Policy, Ministry of Health and Family Welfare (MoHFW) , Dhaka

38. MoHFW (2009). . First Draft of Health Policy, Ministry of Health and Family Welfare (MoHFW) , Dhaka

39. Nanda P (1999). Women's participation in rural credit programmes in Bangladesh and their demand for formal health care: is there a positive impact? Health Economics 1999;8: 415-428.

40. Nazneen Khaleda (2001). Governance of the Healthcare Sector in Bangladesh, CPD, UPL, Dhaka

41. NSDP (2007) Private-Sector Collaboration: Diversifying NGO Funding While Serving the Poor, NGO Service Delivery Program (NSDP), Dhaka, Bangladesh, Technical Report July 2007

42. Oberlander Jonathan (2003). The Politics Of Health Reform: Why Do Bad Things Happen To Good Plans? Health Affairs Web Exclusive, August 27, 2003; http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.391v1?maxtoshow=&hits=10&RESULTFORMAT=&fulltext=The+Politics+Of+Health+Reform%3A&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT , accessed 27.08.2009

43. Oliver T R and Dowell E B (1994). Interest groups and health reform: lessons from California Health Affairs, Supplement (1994); 13(2): 123-141.

44. Oliver Thomas R. and Dowell Emery B. (1994). Interest Groups and Health Reform: Lessons from California ; Health Affairs , Spring (II)

45. Osman, Ferdous Arfina (2004). Policy Making in Bangladesh: A Study of the Health Policy Process. Bangladesh: A H Development Publishing House, Dhaka.

46. Osman, Ferdous Arfina (2005). Implementation Constrained by a Lack of Policy Ownership : Evidence from Bangladesh , The Asia Pacific Journal of Public Administration, Vol. 27, No. 1, June, 1936

47. Osman, Ferdous Arfina (2008). Health Policy , Programs and System in Bangladesh : Achievement and Challenges , South Asian Survey, 15: 2, 23-288, Sage Publications

48. Panday, Pranab (2001).The Role of Bureaucratic Elite in the Policy Making Process in Bangladesh., Socialist Perspective, A Quarterly Journal of Social Sciences, Vol. 29, No. 1-2, September, 2001, India.

49. Pang T, Sadana R, Hanney S, Bhutta ZA, Hyder AA, Simon J (2003). Knowledge for better health - a conceptual framework and foundation for health research systems. Bulletin of World Health Organization, 81: 777-854.

50. Perry Henry B (1999). Quest for a Healthy Bangladesh: A Vision for the Twenty-First Century

51. Perry, Henry B (2000). Health for All in Bangladesh. Dhaka: University Press

52. Pitt MM, Khandker SR, Chowdhury OH, Millimet DL (2003). Credit programme for the poor and the health status of children in rural Bangladesh. International Economic Review 2003; 44: 87-118.

53. PRB (2007). World Population Data Sheet, 2006, Population Reference Bureau

54. Rabbani (2009). Rabbani Golam (2009). Non-Governmental Actors are Coming Forward as Policy Actors: Example from Operational Framework for Pre-Primary Education, Society and Change, Vol. III, No. 2, April- June 2009, OSDER, Dhaka

55. Rahman Redwanur M (2006). Human rights, health and the state in Bangladesh, BMC International Health and Human Rights 2006, 6:4, http://www.biomedcentral.com/1472-698X/6/4, accessed on 22.05.2009

56. Reich Michael R. (1995). The Politics of Health Sector Reform in Developing Countries: Three Cases of Pharmaceutical Policy; Health Policy, Volume 32, Issue 3, Pages 47-77

57. Rhodes R.A.W,(1997). Understanding Governance, Open University Press, Philadelphia

58. Rob Ubaidur and Talukder M Noorunnabi (2007). Health Sector Reform : Lessons from Developing Countries

59. Robinson Scott E. and Eller Warren S (2010). Participation in Policy Streams: Testing the Separation of Problems and Solutions in Subnational Policy Systems, The Policy Studies Journal, Vol. 38, No. 2, 2010, Wiley Periodicals, In

60. Rodrigue Jean-Paul, Comtois Claude, Slack Brian (2009). The Geography of Transport Systems, Routledge, http://people.hofstra.edu/geotrans/eng/ch9en/conc9en/ch9c2en.html, accessed 22.05.2010

61. Roper William L (2007). Here We Go Again—Lessons On Health Reform Advances in science and clinical practice, not the political process, will continue to drive the pace of reform. Health Affairs, November/December; 26(6): 1551-1552.

62. Roper, William L. 2007 Here We Go Again—Lessons On Health Reform : Advances in science and clinical practice, not the political process, will continue to drive the pace of reform, Health Affairs , Vol.26, No.6

63. Schurmann AT, Mahmud S (2009). Civil society, health, and social exclusion in Bangladesh. Journal of Health Population and Nutrition 2009;27:536-44.

64. Shiffman Jeremy (2003). Norms in tension: democracy and efficiency in Bangladeshi health and population sector reform. Social Science Medicine. 2003 Nov; 57(9):1547-57.

65. Shiffman Jeremy (2003). Norms in Tension: Democracy and Efficiency in Bangladeshi Health and Population Sector Reform, Social Science & Medicine, 57(9): 1547-1557

66. Stout Karen Evans and Stevens Byron (2000). The Case of the Failed Diversity Rule: A Multiple Streams Analysis, Educational Evaluation and Policy Analysis 2000; 22; 341

67. Sundewall Jesper et. al (2006). Theory and Practice – a case Study of coordination and ownership in the Bangladesh health SWAp, Health Research Policy and System, 4:5

68. Sutton Rebecca (1999). The Policy Process: An Overview, Overseas Development Institute, Working Paper No, 118, August 1999, Portland House, Stag Place, London SW1E 5DP

69. UHS (2006), Urban Health Survey 2006, BBS, Bangladesh

70. UNICEF (2007).State of the World Children

71. Walt G and Gilson L (1994) Reforming the health sector in developing countries: the central role of policy analysis. Health Policy and Planning, Dec; 9(4) [Abstract]

72. WB (2005).The Economics and Governance of Non Governmental Organizations (NGOs) in Bangladesh, World Bank, August 2005, Poverty Reduction and Economic Management Sector Unit South Asia Region

73. World Bank (2006).Dhaka: Improving Living Conditions for the Urban Poor, Dhaka

74. Yin, R. K. 1994. Case Study Research: Design and Methods, (2nd Edition). Thousand Oaks, CA, Sage Publication

Newspapers:

The Daily Star[34] , 07 April 2008
……....26 July 2008
……13 September 2008
……18 September 2008
…….23 September 2008
……10January, 2009
……07 April 2009
……15 July 2009
……19 August 2009
……16 September 2009
…… 16 October 2009
…… 1 November ,2009
……. 31 January 2010;
……. 17 September 2010
……. May 5, 2010
……. 10 March 2010
The New Age[35], 19 August 2009
…… 31 December 2009;

Websites :

www.searo.who.int/LinkFiles/Conference_Ban-15-Jul.pdf
http://www.gereports.com/taking-healthymagination-to-community-clinics-in-india /
http://www.usaid.gov/our_work/global_health/pop/techareas/repositioning/cbd_depo.pdf
http://www.communityhealth.hhs.gov/homepage.aspx?j=1, Accessed, 22.04.2010
www.unicef.org/health/files/womenfriendlyhealthservices.pdf ,accessed 12.05. 2010
http://www.participedia.net/wiki/CommunityManaged_Clinics_and_Health_Watch_Committees_in_Bangladesh

[34] A national English daily in Bangladesh
[35] Widely circulated national English Daily in Bangladesh

Annex-1: Donor Initiatives in Health Sector of Bangladesh

Organization	Strategic focus	Programme/Activity
DFID	▪ Eradicate extreme poverty and hunger ▪ Achieve universal primary education ▪ Promote gender equality and empower women ▪ Reduce child mortality ▪ Improve maternal health ▪ Combat HIV/AIDS, malaria and other diseases	▪ HNPSP ▪ Technical Assistance for ESP ▪ Grant with World Bank's credit to support HIV/AIDS prevention activities ▪ Polio eradication
CIDA	▪ Improve the quality and delivery of services in health ▪ Education appropriate to the needs of the poor, in particular women and children, ▪ Increase their access to those services.	▪ Health and Population Reform Programme (HPRP) ▪ National Nutrition Project (NNP) ▪ Community Managed Health Care (CMHC) Project ▪ Demand-Based Reproductive Health Commodity ▪ Institutional Support to ICDDR,B ▪ Environmental Technology Verification- Arsenic Mitigation Project - Phase II ▪ Acid Survivors Foundation (ASF) - Phase II ▪ Essential Health Commodities
USAID	▪ Democracy and human rights; economic prosperity; ▪ Investing in human capital. ▪ Better educated, healthier and more productive population	▪ Reduce Unintended Pregnancy and Improve Healthy Reproductive Behavior ▪ Improve Child Survival, Health and Nutrition ▪ Reduce Transmission and Impact of HIV/AIDS ▪ Improve Maternal Health and Nutrition ▪ Prevent and Control Infectious Diseases of Major Importance. ▪ Improve the Quality of Basic Education
SIDA	▪ Health, education, democracy, local administration ▪ Economic development.	▪ Funding to HNPSP
EC	▪ Health, Population and Nutrition ▪ Education ▪ Food Security ▪ Employment Creation	▪ Funding to HNPSP

(*Source : Respective Organization's Website and Collected Documents)*

Annex- 2: Matrix of UN Bodies in Bangladesh

Organizations	Strategy/ Goals	Activities/Programmes
WHO	▪ Reducing excess mortality, morbidity and disability, especially in poor and marginalized populations. ▪ Promoting healthy lifestyles and reducing risk factors to human health that arise from environmental, economic, social and behavioral causes. ▪ Developing health systems that equitably improve health outcomes respond to people's legitimate demands and are financially fair. ▪ Framing an enabling policy and creating an institutional environment for the health sector and promoting an effective health dimension to social, economic, environmental and development policy.	▪ Articulating consistent, ethical and evidence-based policy and advocacy positions ▪ Managing information by assessing trends and comparing performance; setting the agenda for and stimulating research and development ▪ Catalysing change through technical and policy support, in ways that stimulate cooperation and action and help to build sustainable national and inter-country capacity ▪ Negotiating and sustaining national and global partnerships
UNICEF	▪ The initiatives of Unicef in the health and nutrition sector are based on the rights of child individuals, with the aim of addressing their changing needs at different stages of their lives	▪ Child Health Programme ▪ EPI ▪ Control of diarrheal Diseases ▪ Control of Acute Respiratory Infections ▪ Integrated Management of Childhood Illness ▪ Women's Health Project ▪ EOC ▪ Women friendly hospital initiative ▪ Social mobilization and communication ▪ Nutrition and NNP ▪ Control of Iodine Deficiency Disorder ▪ Control of Vit-A deficiency ▪ Control of Vitamin A deficiency ▪ HIV/AIDS ▪ Water and sanitation ▪ Early childhood programme

Organizations	Strategy/ Goals	Activities/Programmes
UNFPA	▪ United Nations Population Fund (UNFPA) is working to reducing maternal mortality, morbidity, infant mortality, and provision of contraceptives to reduce unwanted pregnancies, and stabilizing population growth in the country.	▪ RHIYA (Reproductive Health Initiative for Youth in Asia).
WFP	▪ Improve the human capital of ultra-poor; ▪ Enable ultra-poor to build a sustainable asset base; ▪ Strengthen the disaster preparedness of most vulnerable communities; and ▪ Enhance the access of children from ultra-poor households in food insecure areas to primary education.	▪ Vulnerable group development ▪ Development support in the form of skills training, awareness-raising (on social, legal, health and nutrition issues), basic literacy and numeracy training and small compulsory monthly savings and credit support ▪ Mainstreaming ("graduation") of VGD women into regular NGO development programmes improve livelihoods. ▪ Integrated food security. ▪ School feeding in ultra-poor communities and urban slums.

(Source : Respective Organization's Website and Collected Documents)

Annex-3: List of PRSP thematic sectors and MDGs

PRSP thematic sectors	MDGs
• Agriculture and Environment, including forestry, land use, safe water supply, and water resources management.	MDG 1 &7
• Rural Development, including food security, disaster management, safety net programmes, Micro-credit and rural non-farm activities.	
• Domestic Resources Mobilization.	
• Macroeconomic Stability and Pro-poor Growth.	MDGs 1 & 8
• Finance Sector Reform, including banking, trade and globalization.	
• Private Sector Development	
• Education, including primary and mass education, female education, vocational and technical education.	MDGs 2 & 3
• Women and children advancement and Rights	MDG 3
• Health, including population planning, nutrition and sanitation	MDGs 1,4,5,6 & 7
• ICT and Technology Policy	MDG 8
• Reforms in Governance, including civil service reforms, judicial reforms and law and order.	Cross-cutting all MDGs
• Infrastructure Development and Reform, including power, energy and communications.	

Source: GoB (2005, b).MDG progress report, Bangladesh

Annex-4 :

Name	Parent Organization	Position
A J Faisal	Country Representative, Engender Health	The Working Group
A K Azad Khan	General Secretary, Bangladesh Diabetic Association	The Advisory Committee
A M R Chowdhury	Former Deputy Executive Director, BRAC and Former Dean, James P Grant School of Public Health, BRAC	The Advisory Committee & Chapter Author, Editor or Reviewer
A M Zakir Hussain	Freelance Consultant, Ex-Director, DGHS, MoHFW	The Working Group and Technical Committee
Abbas Bhuiya	Coordinator, Working Group, Bangladesh Health Watch Head, Social and Behavioral Sciences Unit (SBSU) ICDDR,B	The Working Group, Chapter Author, Editor or Reviewer and Technical Committee

Name	Parent Organization	Position
Ahmed Al-Sabir	Director (Research), National Institute of Population Research and Training (NIPORT)	The Working Group
Anwar Islam	Associate Dean and Director James P Grant School of Public Health (JPGSPH) BRAC University	The Advisory Committee and Technical Committee
Asiful Haidar Chowdhury	Assistant Programme Officer, Population Council	Chapter Author, Editor or Reviewer
Bushra Binte Alam	UNFPA	Chapter Author, Editor or Reviewer
Faruque Ahmed	Director BRAC Health Programme	The Working Group and Technical Committee
Ferdous Arfina Osman	Professor, Department of Public Administration University of Dhaka	Chapter Author, Editor or Reviewer
Ferhat Anwar	Professor, Institute of Business Administration (IBA) Dhaka University	Technical Committee
Feroz Ahmed	Research Assistant James P Grant School of Public Health, BRAC University	Chapter Author, Editor or Reviewer
Halida Hanum Akhter	Former Director General Family Planning Association of Bangladesh	The Advisory Committee
Hilary Standing	Visiting Professor James P Grant School of Public Health, BRAC University	Chapter Author, Editor or Reviewer
Ismat Bhuiya	Senior Programme Officer, Population Council	Chapter Author, Editor or Reviewer
J R Choudhury	Vice Chancellor, BRAC University	The Advisory Committee
K M Zahiduzzaman	Field Research Officer James P Grant School of Public Health, BRAC University	Chapter Author, Editor or Reviewer
Khushi Kabir	Coordinator, Nijera Kori	The Advisory Committee
M Abdus Sabur	Public Health Specialist and Team Leader, PSO, HNPSP,MoHFW	Chapter Author, Editor or Reviewer
M Kabir	Professor of Statistics, Jahangirnagar University	The Advisory Committee

Name	Parent Organization	Position
M Q K Talukder	Chairman, Centre for Women and Child Health (CWCH) and Ex-Director, ICMH, MoHFW	The Advisory Committee
M R Khan	National Professor, Chairman & MD of Central Hospital Limited	The Advisory Committee
Mahmudur Rahman	Member & Co-ordinator, Dhaka Community Hospital Trust; Chairman, Governing Body of Dhaka Community Medical College	The Advisory Committee
Mahrukh Mohiuddin	Senior Research Associate/Lecturer James P Grant School of Public Health, BRAC University	Chapter Author, Editor or Reviewer
Maleka Banu	General Secretary Bangladesh Mahila Parishad	The Advisory Committee
Md. Anowar Hossain	Scientist & Head, Clinical Lab Science, ICDDR,B	Technical Committee
Md. Khairul Islam	Country Representative, WaterAid Bangladesh	The Working Group and Technical Committee, Chapter Author, Editor or Reviewer
Md. Mofijul Islam (Shuvro)	Research Associate James P Grant School of Public Health, BRAC University	Chapter Author, Editor or Reviewer
Md. Sayedur Rahman	Associate Professor, Pharmacology Department Bangabandhu Sheikh Mujib Medical University (BSMMU)	Technical Committee
Mian Belayet Hossain	Programme Manager, Safe Blood Transfusion Programme Directorate of Health Services, GoB	Technical Committee
Mohammad Atique Rahman	Research Assistant, Institute of Governance Studies BRAC University	Chapter Author, Editor or Reviewer
Mohammad Jahangir Hossain	Associate Scientist, ICDDR,B	Technical Committee
Motiur Rahman	Editor, Prothom Alo	The Advisory Committee
Nahitun Nahar University	Research Associate James P Grant School of Public Health, BRAC	Chapter Author, Editor or Reviewer

Name	Parent Organization	Position
Naila Z Khan	Professor, Child Development & Neurology Bangladesh Institute of Child Health Dhaka Shishu Hospital	The Working Group
Narmeen Shams	Research Associate, Institute of Governance Studies BRAC University	Chapter Author, Editor or Reviewer
Nazrul Islam	Professor and Former Vice Chancellor Bangabandhu Sheikh Mujib Medical University (BSMMU)	Technical Committee
Rehman Sobhan	Chairman, Centre for Policy Dialogue (CPD)	The Advisory Committee
Rezaul Karim Chowdhury	Executive Director, Coastal Association for Social Transformation Trust (COAST trust)	Technical Committee
Rounaq Jahan	Convenor, Advisory Board, Bangladesh Health Watch & Research Initiatives in Bangladesh	The Advisory Committee
Rukhsana Gazi	Associate Scientist, ICDDR,B	Technical Committee
S K Roy	Senior Scientist, Clinical Sciences Division, ICDDR,B	Chapter Author, Editor or Reviewer
Saber Ali	Director, Clinical Lab Science, ICDDR,B	Technical Committee
Sabina Faiz Rashid	Associate Professor & MPH Coordinator James P Grant School of Public Health (JPGSPH) BRAC University	The Working Group and Chapter Author, Editor or Reviewer
Sadeqa Tahera Khanum	Former Director, National Institute of Preventive and Social Medicine (NIPSOM)	The Advisory Committee
Saima Kamal Thakur	Research Fellow, ICDDR,B	Chapter Author, Editor or Reviewer
Sayed Jahangir Haider	Managing Director Research and Evaluaion Associates for Development (READ)	The Advisory Committee

Name	Parent Organization	Position
Shafayetul Islam	Research Associate BRAC Research and Evaluation Division	Chapter Author, Editor or Reviewer
Shamim Hayder Talukder	Chief Executive, Eminence	Chapter Author, Editor or Reviewer
Sharif Mohammed Ismail Hossain	Senior Programme Officer, Population Council	Chapter Author, Editor or Reviewer
Shehlina Ahmed	Health and Population Advisor DFID, Bangladesh	Chapter Author, Editor or Reviewer
Shivani Murthy	Intern James P Grant School of Public Health, BRAC University	Chapter Author, Editor or Reviewer
Simeen Mahmud	Lead Researcher BRAC Development Institute (BDI)	The Working Group, Technical Committee ,Chapter Author, Editor or Reviewer
Syed Masud Ahmed	Research Coordinator BRAC Research and Evaluation Division	Chapter Author, Editor or Reviewer
Syeda Salina Aziz	Research Associate, Institute of Governance Studies BRAC University	Chapter Author, Editor or Reviewer
Syeda Tonima Hadi	Senior Lecturer, Independent University, Bangladesh	Chapter Author, Editor or Reviewer
Ubaidur Rob	Country Director Population Council	The Working Group
Wahiduddin Mahmud	Professor of Economics, Dhaka University	The Advisory Committee
Zafarullah Chowdhury	Former Coordinator, Gonoshasthya Kendra	The Advisory Committee
Zakir Hussain	Public Health Specialist , Ex-Director DGHS, MoHFW and ex-official WHO	The Advisory Committee
Zarina Nahar Kabir	Associate Professor, Karolinska Institutet	Chapter Author, Editor or Reviewer

(Prepared from BHW, 2010)

Appendix-1: Questionnaire

Policy Makers

a. Name of Individual/ _____

b. Identity :

1. Which were the dominant policy problems in the last health policy making time?
2. How community health issues especially 'community clinic issues' got priority in policy making process?
3. Why community health issues were more dominant than other policy problems?
4. Did situation of health problem play any role to promote the community health issues as policy problem?
5. Did service seeking behavior of community people have any influence to consider the health policy?
6. Did the policy making authority consider international declaration or international policy framework for prioritizing the community health issues?

   ☐Yes ☐ No
7. If yes, which declaration (please specify the name)
8. Did any policy research have any specific influence in community clinic related agenda setting?

   ☐Yes ☐No
9. If yes, which research (please specify the name)……
10. Did any leaning have influence in community clinic related agenda setting?

    ☐Yes ☐No
11. If yes, which one (please specify the name)……
12. Who were the main actors for advocating these issues (community clinic issues)?
13. What was the ruling party role for prioritizing the 'community clinic' issue?

14. Were the leading political leaders of the enthusiastic to promote the issue as a subject of consideration?

☐ Yes ☐ No

15. If yes, then, who were these political leaders (please specify their name)

16. Were some initiatives taken by political leader to promote the community clinic or health issues?

☐ Yes ☐ No

17. If yes, then, what were their activities (please specify their initiatives)

    a.

    b.

    c.

    d.

18. Did political policy/guideline help the policy actors to advocate the community clinic issues?

☐ Yes ☐ No

19. If yes, which political guideline/s-

20. What was the role of bureaucracy (Both health and non-heath professional) in community related agenda setting?

21. Were the health professionals positive to community health issues?

22. Which type of health related organizations or individuals were more active to promote the community health issues?

23. What was role of donor community's to role during community health related agenda setting?

24. How they tried to influence the policy makers?

25. What was role of professional group's to role during community health related agenda setting?

26. How they tried to influence the policy makers?

27. What was role of INGOs to role during community health related agenda setting?

28. How they tried to influence the policy makers?

29. What was role of NGOs to role during community health related agenda setting?

30. How they tried to influence the policy makers?

Policy Advocates

c. Name of Individual/organization _____

d. The main activities of you/your group/organization's work

. Advocacy □ Research □ Program delivery □ Government service □ Other _____

e. The policy area(s) most frequently worked on

□ Health □ social services □ justice □ other_____

1. Were you involved in contributing to promote the community clinic agenda in national health policy 2010?

□ Yes □ No

2. How were you involved in the community health related agenda setting?

□ as a policy making committee member

□ as a civil society member

□ as a member of donor agency

□ as a member of international organization

□ as a media personnel

□ as a known person as in the health sector

□ as a social activist

□ as a politician

□ as a researcher

□ others (specify)…….

3. Have you made use of the any national /international policy document (declaration or framework etc.) in any way in the time of policy advocacy?

   □ Yes □ No

   If yes, please explain:

4. Which documents …….

5. For what purposes have you used the document/ documents?

6. What aspects are useful, and in relation to which situations/activities?

7. Have you found that any sections or aspects of the document met any of your needs, was helpful regarding a policy-related initiative? Please describe how.

8. Has the document had any impact on your group's ability/capacity to intervene in the public policy process (for example, increasing inclusive input or in accessing policy decision-makers)? Please provide examples.

9. How has the document affected your group's approach to influencing policy?

10. Have you found any other avenues, tools, initiatives that have been effective in affecting public policy? Please describe.

11. Which strategies were taken by you or your group or organization to promote your agenda-

a. By doing policy research
   i. Name of the Documents:
   ii. Main Findings:
   iii. Way to reach policy maker:
   iv. Collaboration with :
   v. Was there any influence in public policy

b. Mobilizing policy community
    i. Name of the Program:
    ii. Main Objectives:
    iii. Type of main Participant :
    iv. Collaboration with :
    v. Was there any influence in public policy

c. By arranging seminar
    i. Name of the Seminar:
    ii. Main Objectives:
    iii. Policy Decision Maker/s were presented:
    iv. Collaboration with :
    v. Was there any influence in public policy

d. Personal communication with policy maker
    i. Name of the Policy Makers
    ii. Position in the Government :
    iii. Policy Decision Maker/s were presented:
    iv. Collaboration with :
    v. Was there any influence in public policy

e. Personal communication with policy maker

12. How did you get access to the policy makers?

13. How did you/your group/organization try to influence the policy makers?

APPENDIX-2: LIST OF RESPONDENTS

1. Dr. M. A Sabur, Team Leader, PSO, HNPSP, MoHFW
2. M. M .Reza. Ex-Health Secretary, MoHFW
3. Dr. A.Z. M Zakir Hossain, Ex-Director, DGHS, MoHFW
4. Farida Akter, Co-Convener, Sastho Andolon (Health Movement), Bangladesh
5. Ahmend Al-Kabir, President, TM International (Pannier Health Research Organization)
6. Dr. Akter Hamid, Executive Director, Women Health Coalition, Bangladesh
7. Professor Dr. Abdul Hannan, Ex-Director, ICMH, MoHFW and Chair, MDG-4 Advocacy Forum
8. Dr. Zeba Mahmud, MI, CIDA and Member, Health 21
9. Obaidur Rab, Country Representative, Population Council, Bangladeh
10. Professor Dr. M R. Khan, National Professor
11. Shirin Akhter, Joint General Secretary, Jatiya Samajtantrik Dal (A Political Party of Bangladesh and Member of ruling alliance) and Health and Women Right Activist
12. Sisir Morol, In-charge, Health Desk, Prothom Alao
13. Dr. M.Q.K Talukder, Ex-Director, ICMH, MoHFW
14. Professor M A Faiz , Ex- Director General, DGHS, MoHFW
15. Anowarul Islam, Associate Dean, BRAC University, School of Public Health