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Voice and Accountability: The Role of Maternal, Neonatal and Child Health Committee

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Acronyms

CPD	Centre for Policy Dialogue
DFID	Department for International Development
FGD	Focus Group Discussion
MDG	Millennium Development Goals
MNCH	Maternal, Neonatal and Child Health
NFPE	Non-formal Primary Education
NGO	Non-government Organization
ODI	Overseas Development Institute
PHC	Primary Health Care
PO	Programme Organizer
RED	Research and Evaluation Division
SK	*Shasthya Kormi*
SS	*Shasthya Shebika*
ToR	Terms of Reference
UN	United Nations
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNICEF	United Nations Children's Fund
VO	Village Organization
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Abstract

The study aims to explore how the MNCH committee encouraged community participation and how its communication activities empowered the community people to ensure the healthcare needs of the poor and disadvantaged people. A range of qualitative method was used in the study. In-depth interview, focus-group discussion, informal discussion, observation and document review were used as data collection method. This study conducted in two sub-districts of Nilphamari and Mymensingh districts of Bangladesh during February-April 2010. Thematic content analysis technique was followed. Findings reveal that the committee members took necessary steps to solve the maternal complication by referral, follow-up of referred cases, and providing financial support to the extreme poor if needed, and the committee helped increase the availability of healthcare service providers and improve the nature of services accessible to the community people. However, the capacity of the committees to raise the voice of poor people was fairly limited due to lack of adequate orientation of the committee members and also for lack of publicity about their roles. Besides, the committee could not run properly due to disagreement between power and literacy among the committee members. The MNCH committee has potential as it allowed the people's voice and could, thus, serve as a pathway through which ordinary people could hold local health authorities and local service providers to account. The findings informed the further development of an enabling environment in which the voices of MNCH committee members and community people would be stronger.

Executive summary

Introduction

If health services are to be improved, raising the voice and accountability of both community members and health service staff is important. Many partnership initiatives have shown achievements in improving health services by facilitating people's participation and by identifying mechanisms whereby the voice of those involved can be effectively heard. To ensure community participation, BRAC's Maternal, Neonatal and Child health (MNCH) programme introduced the MNCH committee in 2005. The committee's terms of references (ToR) were to raise awareness about MNCH healthcare services in the community and local hospitals, and motivate community members to use improved healthcare services.

Objectives

The study aimed to explore how the committee members encourage community participation for health promoting practices and how the committee's communication activities empowered the community people to ensure the healthcare needs of the poor mothers and childrens are met by local health services.

Methods

This qualitative study was conducted in two sub-districts of Nilphamari and Mymensingh district of Bangladesh during February to April 2010. In-depth interviews with committee members, focus group discussions (FGD) with community people, and informal discussions with MNCH staff, document review and observation methods were used to collect data. The respondents were asked about composition of their committees, activities, participation, strength and weakness of the committee. Thematic content analysis technique was followed.

Major findings

Using mechanisms that are similar to traditional patron-client relations, MNCH committee members have had modest success in motivating and encouraging community members to follow practices recommended for improved MNCH. There were some reports of improved timekeeping and behaviour with patients by health facility staff as a result of follow-up by MNCH committee members. But the MNCH committee is still not adequately prepared for its role in assisting community members to raise their voice in order to hold health service providers to account for the standards of their performance. Community members living in the periphery or with no direct links to committee members are unaware of the role of the MNCH committee. In addition, the functioning of the committee was also hampered because

of complex tensions between committee members, especially where those with lower social status had higher education level than acknowledged community leaders.

Conclusion

The study findings show that the limited effectiveness of the MNCH committee is still dependent on the use of patron-client relations. With more effective training for carrying out communication and advocacy roles, it has further potential to allow the people's voice to be heard. It could, thus, serve as a pathway through which ordinary people might hold local health authorities and local service providers to account. These study findings informed further development of an enabling environment in which the voices of MNCH committee members and community people would be stronger. Recommendations include revision of committee ToR, improved training in MNCH practices, committee procedures, communication and advocacy, increased publicity about role of MNCH committee and date, time and venue of meetings.

Introduction

In recent years the notion of 'voice and accountability' has been developed and applied in the field of social development in both low and high income countries (DFID 2007). The overall goals of voice and accountability interventions are the improvement of service quality and organizational governance, and changed behaviour on the part of both service providers and users. In brief, interventions to improve voice and accountability endorse the participation of and increase the capacity of community members to communicate their perspectives on health or other government, non-government organization (NGO) or private services. They enable community members to voice demand for service improvements (DFID 2006, Manandhar *et al*. 2004, Rifkin 2003). Also, policy-makers and service providers are held accountable to community members and service users for their actions and standard of work.

Enhanced voice and accountability derive from an exploration and analysis of opportunities and constraints, and the building of institutional, organizational and individual capacities (ODI 2007). Community members and service providers are in increasingly regular and open communication with the result that services are more likely to be responsive to the ideas, concerns and suggestions of clients. Service users are, in turn, increasingly aware of the technological and organizational context within which the service providers work. Service users, therefore, also come to understand what they can do to contribute to the delivery of a more effective and efficient service (ODI 2007). Organizational governance is also improved. United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) summarizes good governance as having 8 major characteristics. This is participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive, and follows the rule of law. *'It assures that corruption is minimized, the views of minorities are taken into account and that the voices of the most vulnerable in society are heard in decision-making. It is also responsive to the present and future needs of society'* (UNESCAP 2011).

Interventions that seek to increase voice and accountability and improve governance inherently recognize and address the power differentials and communication barriers that commonly exist between professionals and community members, particularly the poor and disadvantaged.

Participation and voice

There is evidence that community participation in relation to healthcare contributes to positive outcomes (ODI 2007, Goetz *et al*. 2003, Malena 2004). Indeed, Newell's analysis of successful health projects where community participation was a key factor strongly influenced the development of the concept of primary healthcare (Newell 2011). However, the global economic situation and a concern that active community

participation in primary healthcare (PHC) was idealistic swiftly led to the implementation of selective primary healthcare in the 1980s (Rosato *et al*. 2008). UNICEF influenced by Walsh and Warren (1979) focused on the 'do-able' - growth monitoring, oral rehydration, promotion of breastfeeding, immunization, family planning, food supplementation and female literacy (GOBIFFF). Although selective PHC was critiqued by authors such as Werner *et al.* (1997) who argued that selective primary healthcare failed to address the societal and structural factors that were associated with poor health.

By 1993 the World Bank, as an expression of its underpinning neo-liberal economic ideology[1], was promoting investment in health. Because, 'good health increases the economic productivity of individuals and the economic growth rate of countries investing in health is one means of accelerating development' (World Bank 1993). In this conceptualization, a 'low cost and highly effective' essential package of services was to be delivered by governments. Participation was envisaged as households improving their own health as economic growth occurred.

By 1997, however, it was becoming apparent that national economic growth did not have equitable results. There was a growing divide between the rich and poor and this was visible in the health disparities (Gwatkin 2000). What we now understand as the Millennium Development Goals (MDG) were originally just a small sub-set of objectives found in the development and poverty eradication section of The Declaration. The Declaration recognized that, 'while globalization offers great opportunities, at present its benefits are very unevenly shared, while its costs are unevenly distributed' (United Nations 2000, p2). In the same document participation was referred to in reference to 'more inclusive political processes' framed in statements that related to fundamental values (Freedom, equality, solidarity, tolerance, respect for nature and shared responsibility), peace security and disarmament, protecting our common environment, human rights, democracy and good governance, protecting the vulnerable, meeting the special needs of Africa and strengthening the UN (United Nations 2000). Just two years later (United Nations 2002) the joint statement by the UN Committee on Economic, Social and Cultural Rights and the UN Commission on Human Rights' Special Rapporteurs on Economic, Social and Cultural Rights affirmed that, 'that human rights, including economic, social and cultural rights help to realize any strategy to meet the MDGs for example by:... raising the level of empowerment and participation of individuals' (United Nations 2002, p1). WHO in the same year (WHO 2002) echoed this. It described community participation a '*a process by which people are enabled to become actively and genuinely involved in the defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change*' (p10). However, by 2005 the participation of community in scale up towards meeting, MDG goals was exercising planners (UN Millennium

[1] Neo-liberal economics hold that the most efficient allocation of resources is achieved through the open market system, reduction of public expenditure on social services, privatization of state owned enterprises, deregulation of the private sector and increasing emphasis on the individual rather than the common good.

Project 2005). The authors anticipated involvement and ownership by communities and civil society organizations, training of community health workers, community involvement in monitoring and reporting and 'putting communities at the centre' of scale up through decentralization and community planning (UN Millennium Project 2005). With the emphasis having shifted from individuals to communities, as we near the 2015 target date, the focus is now increasingly on the international and donor communities so that, as the UN Secretary General states, 'We must not fail the billions who look to the international community to fulfil the promise of the Millennium Declaration for a better world' (United Nations 2010). Individuals and communities are lost in the, implicitly dependent, 'billions'. The dependence of low income countries on the international community now seems to trump the involvement of the poor and vulnerable in more 'inclusive political processes' envisaged in 2000 (United Nations 2010). While at macro-level in the Middle East and North Africa large scale political participation, largely mediated through mobile phone and web-based social networks, has resulted in national movements referred to as the 'Arab spring' (Hardy 2011, Randeree 2011, Akbar 2011). At micro level in discrete projects community participations continue to occur.

Gaventa and Valderrama (1999) identified a shift in the nature of participation:

From	To
Beneficiary	Citizen
Project	Policy
Consultation	Decision-making
Appraisal	Implementation
Micro	Macro

With respect to health development, there have been numerous attempts in many parts of the world to expand the role of the community (Ahmed unpublished). Currently we see both types of participation described by Gaventa and Valderrama (1999) occurring. Draper *et al*. (2010) also note the persistence of the notion community participation the health literature; the heterogeneous nature of communities and the diverse expressions of community participation. After Kothari and Cooke (2001), they describe the co-option of community participation as a technocratic solution to economic problems that manifest themselves in poor health problems. Furthermore they describe the limited capacity of communities to effectively communicate in the context of wider political and social realities. Draper *et al*. (2010) offer a framework by which to describe and evaluate the process of participation. Thus, each project is evaluated by its leadership, planning and management, women's involvement, external support and monitoring and evaluation processes. The level of community participation from mobilization through collaboration to empowerment is measured for each of the processes.

In relation to maternal, neonatal and child health (MNCH), where engagement of mothers with MNCH services is strongly influenced by cultural norms and practices, there is emerging evidence that community participation is important. Rosato refers to active or passive community involvement (Rosato *et al*. 2008). Without the

participation of all key players including men, elders such as mother-in-law and community leaders the development and scaling up of interventions and services is likely to have limited effect.

Large-scale studies in South Asia have evaluated the role of community support and advocacy groups in combination with community people and trained birth attendants (Hossain *et al.* 2009). Although improvement of maternal and neonatal health as a result of such intervention is unclear, there seems to be an effect on family awareness and on specific healthcare practices such as the use of delivery kits, breastfeeding, and care-seeking for newborn and maternal illness.

The formation of women's group or community support group is an important mechanism by which participation is achieved. In several countries such as Bolivia, Kenya, Ethiopia, Malawi, Nepal, India and Pakistan there are indications that this strategy helps improve household practices for maternal and newborn care (Rosato *et al*. 2006, Manandhar *et al*. 2004, Tripathy *et al*. 2010, Bhutta *et al*. 2008). Previous research has showed that mother's community participation in health programmes can influence better child health. The Warmi Project in Bolivia, the MaiMwana project of Malawi, the Makwanpur trial in Nepal and Ekjut trail in Jharkhand and Orissa, India tested a participatory intervention with women's groups, lead by locally recruited women facilitator, and were supported through a community mobilization action cycle. The group discussed maternal and newborn health problems, developed strategies and plans to solve them and implemented and assessed their own solutions in co-operation with community leaders, men and health workers (Rath *et al*. 2010, Morrison *et al*. 2005). These two trials (Manandhar *et al*. 2004, Tripathy *et al*. 2010) found a tremendous reduction in neonatal mortality. Community health committees in Pakistan achieved to establish an emergency transport fund for mothers (Bhutta *et al*. 2008). Nobles and Frankenberg (2009) also found a relationship between mother's access to social capital via participation in community activities and their children's health in Indonesia (Nobles and Frankenberg 2009). The Kakamega project in Kenya women in communities were involved to identify their own problems, collect their own data, implement their own solutions and select their own community health workers (CHW). The project achieved improvements in primary care, immunization, water supplies, family planning, and malaria control (Rosato *et al*. 2008). A Study in Ethiopia showed that mobilizing women's group could effectively recognize and treat malaria at home (Kidane and Morrow 2000).

In reality, however, not only people's local participation but also the clear articulation of their perspectives and ideas at higher levels of the healthcare system is crucial for improving access of disadvantaged populations (ODI 2007). In many low income countries, citizens' voices often remain unheard and the citizenry is simply too weak to exert any influence. The state is therefore not sufficiently accountable to its citizens.

Accountability is the, "capacity and will of those who set and, crucially, implement a society's rules- including the executive at different levels and public officials – to respond to citizens' demands" (ODI 2007, p.2, See also O'Neil *et al*. 2010 and

Campbell and Graham 2006). Accountability involves measures to ensure that the person or organization with the authority to provide a service actually delivers that service to the best of their ability (O'Neil *et al*. 2010). Mechanisms need to be in place for providers and policy-makers to be answerable for their decisions; to be obliged to justify their position or approach and to be transparent. It demonstrates that they have delivered what it was agreed that they would deliver (Campbell and Graham 2006, Goetz and Gaventa 2003). It is also important that community members can enforce a response and to use sanctions if services are inadequately provided (DFID 2007, DFID 2006). However political client relationships often get in the way of the implementation of sanctions. Poorly performing health workers escape sanction because of the influence of their political patrons (World Bank 2004).

Recent literature has examined how policies and interventions funded to increase the impact of the citizens' voice on state accountability works in practice (Goetz and Gaventa 2003, Foresti *et al*. 2007, Berlan *et al*. 2011). Berlan *et al.* (2011) in their integrative paper conclude that, 'evidence on factors and interventions shaping health provider accountability is thin. For this reason, it is not possible to draw firm conclusions on what works to enhance accountability'. However, these authors suggest four ways in which 'provider responsiveness' (see also WHO 2005) might be improved. These are listed as:

1. Creating official community participation mechanisms in the context of health service decentralization;
2. Enhancing the quality of health information that consumers receive;
3. Establishing community groups that empower consumers to take action; and
4. Including NGOs in efforts to expand access to care.

Poor people in seeking improved healthcare, has improved accountability on the part of the health system. For example, Naripokkho, a national NGO worked together with a local NGO (Sankalpa) in one sub-district in Bangladesh. Their main concern was that poor women received good healthcare and did not die from preventable causes. Therefore, to improve health and medical services at the hospital, Sankalpa revived the existing but non-functioning *Upazila* Health Advisory Committee which became effective in improving staff behaviour and linked with journalists and the local MP to access improved resources for the local hospital. It was particularly useful as it vehicle through which ordinary citizen could hold local health authorities and service providers to account (Naripokkho 2010).

BRAC MNCH committee

BRAC is a large Bangladeshi NGO. Its MNCH programme seeks to reduce the persistently high mortality and morbidity rates of mothers and children in Bangladesh. Community[2] services for antenatal and normal delivery care are delivered through

[2] We recognise that the term community is contested. For the purpose of this paper we define community as the population residing in the geographical area served by the SS and SK.

BRAC *Shasthya Shebika* (SS), who are volunteers, and *Shasthya Kormi* (SK). In addition, SSs and SKs work with programme organizer (PO) to ensure that women, neonates and children with complications are effectively referred to a suitable primary or secondary level health facility. Occasional performances of *jarigan* (traditional songs) and drama are used to communicate health messages.

The MNCH committee is one of the major components of rural MNCH programme. Its composition and function is determined by a terms of reference (ToR). An MNCH committee consists of 11 people from the same community representing different professional and community groups (Table 1). Fifty percent of the members are female. All the members are selected mainly through motivation by the BRAC MNCH staff. The committees arranged a quarterly meeting at which they identify community health problems and take initiatives to solve them.

Table 1. Composition of BRAC MNCH committee

SL	Position	Gender	Occupation
1	Chairperson	Male/Female	Member of Union *parishad*
2	Secretary	Female	*Shasthya Kormi* (SK)
3	Treasurer	Male	School teacher/*Imam*
4	Member	Female	NFPE school teacher (if available)
5	Member	Female	VO member (if available)
6	Member	Female	VO member (if available)
7	Member	Male/Female	Member of the NGO organization
8	Member	Male/Female	School teacher
9	Member	Male	Village elite
10	Member	Male	Religious leader
11	Member	Female	*Shasthya Shebika* (SS)

In some programme areas, MNCH committees are functioning. The role of the MNCH committees is to raise awareness among community members about what they can do to improve MNCH, especially how to recognize danger signs and what action to take. Specifically the members of the committee promote the preparation of birth plans, including saving for an emergency and the use of skilled birth attendants and neonatal health workers. The committees encourage and help the SSs to carry out their duties in the community and help refer and follow-up referred cases. The MNCH committee is also tasked with advocating improved quality of services at health facilities thereby holding local service providers accountable for the provision of quality services to committee members who are *de facto* community representatives (BRAC 2010).

In this review of the literature we have shown how concepts of community participation in health were critical to the early implementation of primary healthcare. However, in the context of limited resources and the growing influence of the World Bank neo-liberal economic model on government health services through the 1980s and 1990s and on the way activities aimed at meeting the MDGs are focused in the first decade of the 21st century we argue that community participation is overall trumped by increasingly top down approaches led by the international donor

community. Parallel to this is the growth of local initiatives, including the BRAC MNCH committee, that seek to increase the voice of community members, especially the poor, with the objective of holding service providers more accountable for delivery of quality services. However, we note that evidence in the literature for community members effectively being able to hold service providers to account is slight. MNCH committees are included in BRAC MNCH programme as a means of increasing community participation; supporting MNCH behaviour change in the community and advocating for improved health service delivery. Within BRAC routine programme monitoring and evaluation there was very limited evidence about the way the MNCH committees worked and the outcomes achieved in relation to community practices and improved service delivery. For this reason we carried out this modular study.

Objectives

The study was carried out to describe how:

a. The MNCH committee members encourage community participation for MNCH promoting practices; and

b. The MNCH committee's communication activities empower community people to shape services so that they become more responsive to people's need.

Methods and Materials

Study design

A qualitative exploratory study was designed to provide in-depth insight into the role and function of MNCH committees.

Operational definitions

Community participation - active participation in the practices that promote MNCH and in planning, monitoring and influencing health services from community to secondary level.

Empowerment - the capacity to change behaviours at a personal and family level and also to both challenge and engage with professionals, government officers and others ascribed with high social status (in Bengali *boro-lok*).

Voice - the capacity of all people, including the poor and most marginalized, to express views and interests and demand action of those in power. The focus is not on the creation of voice for its own sake but on the capacity to access information, scrutinise evidence and demand answers with a view to influencing governance process (ODI 2007).

Accountability - 'The capacity and will of those who set and, crucially, implement a societies rules - including the executive at different levels and public officials – to respond to citizens demands. Answerably and enforce ability are critical dimensions of substantive accountability and real accountability implies some form of sanction - be it through the ballot box, legal processes, institutional oversight bodies, or media exposure' (ODI 2007).

Selection of study area and MNCH committee

To explore the role of the BRAC MNCH committee we used a stratified sampling method. Firstly, districts were selected purposively according to the length of time the MNCH intervention had been running. Subsequently, two sub-districts Jaldhaka and Haluaghat were randomly selected. It should be noted here that each sub-district cover multiple unions and wards. The programme plans indicate that one MNCH committee should function in each ward. However, because our focus was on the role and function of the MNCH committee, in the next step the three longstanding and active committees as indicated by,

- The holding of at least three meetings since their formation;
- Evidence of some community-based activities;

- Record keeping; and
- Availability of committee members to the researchers.

Study population

The study population included committee members including chairman and treasurer. Special attention was given to the selection of respondents, so that, in addition to the chairman and treasurer other committee members were also represent. The study also included secondary target population; such as community people and BRAC health staff who were likely to have influence on the committee formation.

Research methods

In-depth interview, focus group discussion (FGD), informal discussion and document review were used for collecting information.

Data collection tools

Separate checklists were used for in-depth interviews, informal discussions and for FGDs. Checklists for data collection were pre-tested. Based on pre-testing, the tools were revised before final data collection. All sessions were tape-recorded with prior consent of the respondents.

Data collection procedure

Data were collected during February-April 2010 through a team of two researchers of the Research and Evaluation Division (RED), an anthropologist and a sociologist. Table 2 shows the summary of data collection procedures used for specific objectives. In-depth interviews and informal discussions were continued until theoretical saturation occurred, that is further data collection added nothing to the categories; relationships between categories and the core category.

In-depth interview and informal discussion

Thirty in-depth interviews with committee members were conducted to describe social mobilization techniques used to encourage participation of community people. Challenges, problems, failures and successes experienced in the attempt to raise the voice of the community to ensure services became more responsive were explored through in-depth interviews. Twenty informal discussions with MNCH staff were conducted.

Focus group discussion

Six FGDs with community people were conducted to analyze their participation, expectation, demand and complaints against MNCH committees (Table 2). Each

FGD consisted of six to eight people. One moderator and one assistant moderator conducted the FGD sessions where the moderators' role was to facilitate discussions and encourage active participation. The assistant moderator helped with operating and record equipments, documented the whole process of group discussions and took notes.

Observation

Two committee meetings were observed in both sub-districts of Jaldhaka and Haluaghat. The objective of this observation was to document the participation of community people and committee members in the meeting. Issues addressed were how the committee members and community interact with each other; how they identify the problems; strategies for the solution of problems; and the extent of women's participation.

Document review

Secondary data from the minutes of committee meetings, registers, and published reports were collected and analyzed.

Table 2. Data collection methods and category of respondents used in the study

Research Objective	Data collection techniques	Respondents	Issues addressed
To know how the committee members encourage community participation for health promoting practices	• Thirty in-depth interview • Eighteen informal discussion • Programme documents review • Observation of two committee meeting	• Committee members • MNCH staff	• Composition of committee • Activities • Participation • Strength • Weakness • Expectation
To describe how the committee's communication activities that empower community people to shape services so that they become more responsive to people's needs	• Six FGDs	• Community people	• Successes • Failure

Quality control

At data collection level principal investigator (anthropologists) and co-investigator (sociologists) conducted the interviews themselves. Data were transcribed and verified for accuracy under close supervision of the principal investigator. Additional assessment of new theme and reviews across interviews for inconsistency was checked and thoroughly scrutinized.

Analysis

Data were transcribed manually by experienced transcriber in RED, the same anthropologist and sociologist, who collected and analyzed the data. In line with the research questions and operational definitions, data were coded line by line. Unexpected concepts were also coded. Thus, we used both deductive and inductive analysis.

Subsequently, coded data were compiled and summarized before manual analysis when categories and theme were identified. Findings were triangulated by comparing and contrasting perspectives of the different respondents. However, we were careful not to squeeze the data into thematic molds. We recognize that in a study of this type differing perspectives are normal.

Ethical consideration

The study protocol was approved by technical advisory group of rural MNCH programme. Verbal informed voluntary consent was obtained from all the respondents. Respondents were pre-informed about the confidentiality of the source of information and had freedom to withdraw from the discussion at any time.

Results

As a preface to the presentation of the results, two things should be mentioned here. Firstly, we purposefully selected areas where the MNCH committees were working because in most of the MNCH areas, they are simply not functioning. Secondly, the MNCH committee is just one of the health-related committees in BRAC areas. These findings, therefore, are related to functioning MNCH committees.

Rigidity in composition of committee

The membership and ToR for the MNCH committee have been described in the introduction. The ToR was perceived by the respondents as being very rigid. Document review and informal discussions with programme staff revealed the ToR, including selection criteria for membership, was perceived as very rigid. If the designated committee members, the chairperson, secretary and treasurer, did not call a meeting or could not attend, then the meetings might not be held at all. Also, respondents perceived that because an explicit statement to this effect was not included in the ToR, there was no scope for co-opting other community members who might be interested in the MNCH programme. A BRAC PO commented,

> *"There are some committee members specially Imam and non-formal primary education (NFPE) teacher who always remain busy and did not manage time for the meeting. Committee cannot select another person instead of them because, committees need to fulfill the selection criteria."*
>
> *(Informal discussion-PO, MNCH programme, BRAC)*

In practice, selection of the committee members was done basically by the BRAC MNCH staff. The MNCH staff are supposed to orientate committee members about the MNCH programme and their responsibilities. However, no committee members had received training from programme. In the absence of proper technical and procedural guideline, committee members depend on MNCH staff instead of discussing issues in an informed way and making their own decisions. This situation was felt most critically by member-secretary and treasurer.

> *"I did not receive any training. Our committee does not have any fund. I am the treasurer but do not know as a treasurer what my responsibilities are. If nobody gives me the instruction how can I understand what should I do or not to do. I always asked to bhai* (BRAC staff) *about my duties."*
>
> *(In-depth interview, Treasurer, MNCH committee)*

Limited attendance at the meeting

According to ToR, committee members should meet quarterly. It was found from the document review and observation that committee we purposively selected for inclusion met quarterly. However, no meeting all the members present. Poor attendance by committee members was caused by a variety of, often overlapping factors.

The timing of the meetings did not suit the member's availability. Having been selected, there was little interest to attend the meeting. Only five or six out of 11 members were present in meeting. NFPE teachers were particularly irregular in attendance.

> *"I cannot adjust my school time with meeting. I am not interested to attend meeting."*
>
> *(In-depth interview, NFPE teacher)*

Community people were not told about the date and time of the committee meeting. Our FGDs sought to get participants to talk freely and discuss openly to collect individual, group and group interaction data[3]. Thus, we found only six community people among 36 FGD respondents knew anything about the MNCH committee meeting. These six were directly connected with committee members. They were basically relatives or neighbours of the committee members and lived close to them.

Strength of the committee

To find out the strength of MNCH committee in-depth interviews with committee members, informal discussions with MNCH staff and FGD with community people was conducted. Community people who were not committee members were also encouraged to participate in discussions. The majority of respondents mentioned that regardless of socioeconomic status, in the meeting committee members and community people that were present enjoy the equal opportunities to raise any issues regarding MNCH. MNCH committee listen to the voices of poor people specially the voice of women (Fig.1).

> *"MNCH committee support and encourage community people to raise voice (Dabi). Community people including poor and females get the opportunity to raise their question in the meeting."*
>
> *(Informal discussion, PO, MNCH Programme, BRAC)*

[3] There is a theoretical discussion about the unit of analysis in FGDs-individual data, group data and/or group interaction data. Duggleby W (2005). What about focus group interaction data? *Qualitative Health Research*, 15, 832-840. See also, Onwuegbuzie AJ (2009). A qualitative framework for collecting and analyzing data in focus group research. *International Journal of Qualitative Methods* 8(3).

Figure 1. Although women are seated on the mats, our observations suggest that this does not prevent them voicing their concerns about MNCH issues

At personal level committee members maintained strong communication network with the community people living close to them and directly related to them. These local community people can share their problem with committee members. Thus, the MNCH committee showed their strength in addressing local problems which are commonly discussed, such as the unavailability and negative attitude of service providers. The community people reported non-availability of service providers and misbehaviours of service providers with clients was common at health facilities. However, after formation and activity of MNCH committee, absenteeism of providers and patient's waiting time is now decreasing. Regarding this issue a woman described her experience which was mentioned below:

> *"I was suffering from a gynecological disease (meyeli asukh) and went to sub-district hospital for treatment. Doctor was absent there. I asked when the doctor would come. Medical staff did not answer and behaved with me rudely. I came back to my home and communicate with one of committee members. The committee member is a health assistant. He communicated with a hospital doctor and told me to use his reference next time at hospital. I went to hospital again and found same staff behaved with me politely when they found that a committee supported me to be in the hospital. I did not wait for a long time when I used reference of the health assistant. Now waiting time for service little bit decreased not only in my case but also who used the reference of committee. Things are positively changing after formation of committee."*
>
> *(FGD, Community people-Female group)*

Unity among MNCH committees and local community people compelled the local health service providers including MNCH staff to listen their voice. Furthermore, to

improve services, the committee sent recommendations to the ward member. The ward member is the locally elected person and representative of government at local level. In addition, ward members are the chairman of MNCH committee; thus he or she can influence local health providers with his political power to get service delivery easily.

After being assisted a community man mentioned in relation to his wife,

> *"A health assistant is a committee member. He talked over phone for me with a hospital staff. Now non-availability, misbehaviour of service providers and waiting time to receive treatment is starting to decrease which I experienced previously."*
>
> *(FGD, Community people-male group)*

Committee members take necessary actions for the local poor to encourage them to receive care. A community man mentioned,

> "*I am poor, I do not have money to arrange ambulance to take my wife to hospital. Committee members gave me some money and help me to arrange ambulance."*
>
> *(FGD, Community people-male group)*

Success of the committee

Committee members found differing views held by elderly family members and young mother regarding maternal and newborn care. Committee members meet with family members of pregnant women and educate them as necessary. They discussed with older community people specially mothers-in-law, older people and husband regarding maternal healthcare, birth preparedness, newborn care, early attendance in hospital in the case of complication. The case study is mentioned by community women below to describe the scenario:

> *"There are some elderly people in our community who preferred traditional practice regarding newborn care. Especially mothers-in-law encourage their daughters-in-law to shave newborn hair just after delivery. They perceived newborn hair is impure. I know they were wrong but it was difficult for me to go against elderly people. I discussed this issue with one of my neighbour. She was a MNCH committee member. I proposed her to discuss the issue in a committee meeting. The committee accepted my proposal and discussed about the newborn care in next meeting. Not only had that chairman of the committee come to discuss this issue with my family also. Now in our community elderly people are becoming aware of newborn care. They also are becoming aware of early attendance in the case of complication."*
>
> *(FGD, Community people-female group)*

Another man (also a husband of a pregnant woman) mentioned,

> *"How could I refuse to admit my wife in hospital when an honorable person and his committee came to our home and helped us? Now my family and the community people are becoming aware to receive proper care."*
>
> *(FGD, Community people-male group)*

The chairman of a MNCH committee also mentioned,

> "*Honourable and representative persons including teacher, health assistant, religious leaders, and member of Union Parishad were selected as committee members. They could easily communicate with referral PO, even with some hospital staff or doctor. On the other hand, ordinary community people could not do this. They come to committee for this purpose. This kind of communication with service providers minimized the gap between service provider and the community people. He also added that SS and SK were also committee members. They were familiar with community so they could identify health problem easily. When a health problem was identified, committee could initiate necessary steps to solve the problems."*
>
> *(In-depth interview, Chairman, MNCH committee)*

Based on our data including the statements above, the major health problems were identified and the initiatives taken by committee are described in following box.

Problem identified	Decisions implemented
Low awareness about newborn and maternal care	A number of awareness-raising meetings with community people were organized by MNCH committee.
Pregnant women are reluctant regarding birth preparedness	The committee members discussed and educate family members specially mother-in-law and husband
Require assistance for referral	Committee members were directly involved in referring and follow up the mother
Rude behavior of service provider	Committee members met with service providers and support community people at hospital

Weakness of the committee

MNCH staff mentioned power relations among the committee members as a reason for not attending the committee meeting. These power relations mainly played between educated and less educated committee members. A health assistant who is also a committee member mentioned,

> *"I am more educated than the committee chairman. I dislike attending meeting. I think he is inefficient to chair MNCH committee meeting*."
>
> *(In-depth interview, committee member)*

The study also found that poor record-keeping by the committee is another weakness. Our document review shows that only in Jaldhaka the committee maintained records of the meeting date, place, and attendance sheet, topic of discussion and decisions of the committee.

Views of community people towards committee

FGDs reveal that community members, who are not closely related to the committee members, felt that the MNCH committee members are not yet familiar or well known to them. Those community members who were related in some way to the committee members knew that the committee organized meetings in their areas. Community people were present in the meeting, but only when they had free time and noticed about the time and place. Though there were no fixed places of meeting, usually it was held in courtyard of committee members' house (Fig.1). Community people reported that the following issues were supposed to be discussed in the meetings:

MNCH committee	Pregnancy	Delivery	Referral	Newborn care	Others
- Activities - Aim	- Risk factors - Death during pregnancy	- Safe delivery - Use of delivery kits - Birth planning - Risk factor after delivery	- Where - How - Activities of referral PO's	- Neonatal care - Risk factors - Birth asphyxia	- Misoprostrol use - Diarrhea - De-worming - Fistula - Activities of SS, SK, newborn health worker (NHW) and help them to carry out their duties - Emergency fund

A few participants of FGDs reported that some committee members met them after formation of MNCH committee. By contrast, participants of FGDs from the peripheral areas had little knowledge about committees. Most had not attended any committee meetings.

Informal discussion with BRAC manager and PO reveals negative views toward committee prominently held by older members of the community. This was also common among who did not know more about activities of MNCH committee. Manager and PO mentioned that elderly people perceived that delivery was a normal family matter. Committee members were outside from the family so community people could not depend on the committee.

Furthermore they considered that:

- The MNCH committee consists of ordinary people and they are neither knowledgeable nor powerful persons and do nothing; and

- MNCH committee is not very powerful to influence the government hospital to provide better services.

Here is a quotation from a male respondent regarding his views on committee,

> *"Committee is not influential or powerful to do extra ordinary things*."
> *(FGD, Community people-male group)*

Voice and accountability in practice by the committee members

All committee members interviewed mentioned that in the quarterly committee meeting all members and community people could express their opinion freely. Every one's opinion was well respected and voice was taken into account. Regarding these issues this statement of a FGD participant is indicative of the voice of majority,

> *"In the meeting there are committee members and community people participated. Not only the committee members but also community people can express their opinion without hesitation. We are not committee members. We are ordinary community people but no one stops us talking. Even the chairman of the committee and MNCH staff encourage us to share our problems with them during meeting time. They respect our opinion to identify and solve the problems."*
> *(FGD, Community people-male group)*

Although certain committee members sat on chairs and others on mats, there was a free exchange of views (Fig.1).

Though the minutes of the meeting was not maintained properly, committee members mentioned that the meeting was started with reviewing the issues discussed in the previous meeting. The quarterly meeting plan, time and date were fixed on the basis of availability of committee members. Discussion on local health problems was main concern in committee meeting. To solve those problems decisions were taken and actions initiated and implemented on the basis of the opinion of the majority.

Views of MNCH staff towards the MNCH committee

MNCH staff considered MNCH committee as the vehicle for reaching the community people easily. MNCH staff mentioned that though there was no significant improvement yet had been made by the committee, without committee's participation motivation of community people was difficult. One PO of MNCH programme mentioned that,

> "*Sometimes it is very difficult for us even difficult for CHWs (SK and SS) to motivate community people, especially in the case of referral and to get them involved in other services. But we observed that committee members can easily motivate the community people."*
> *(Informal discussion, PO, MNCH programme, BRAC)*

This is exemplified by the case studies. The SK identified a mother with high blood pressure. She advised her family to visit a doctor. Family of the woman disagreed and refused to go to hospital. The family did not perceive high blood pressure during pregnancy as a risk factor. SK informed the PO. PO met with the family but decision remained unchanged. Then PO discussed this issue with the MNCH committee. Chairman and other members of the committee met with the family again and discussed the possible risk during delivery. The family was motivated and with the financial help of committee arranged ambulance and went to hospital. The committee followed up the mother after returning home.

A husband of a woman stated,

> *"MNCH committee explained the risk during pregnancy. Member of the Union Parishad and the chairman of the committee come to meet with us. I agreed with them. How could I deny when honorable person come to our home for our betterment."*
>
> *(FGD, Community people-male group)*

MNCH staff mentioned the committees help to identify the poor as they are well informed about the financial condition of community people. Committees also help to refer and follow-up referred cases after coming back from hospital. Their contribution to help the poor including financial help (committee was not assigned any financial support to the poor by BRAC but sometimes the committee personally provides financial support to the extreme poor) and to encourage women to access health services is appreciable.

It was disappointing that MNCH committees were functional in few areas. From our research we note that where they do exist, MNCH committees feel themselves to be poorly prepared for their role and constrained by the tightly defined ToR. Furthermore, their membership is drawn from those who reside in the major centers of the ward. While the committee members have showed some success in both communicating health messages and advocating for better services these efforts are primarily effective for those who are personally known to committee members or live locally near them, rather than for community members throughout the area.

Discussion

In South Asia there is some evidence that with community participation in whatever form, there is some improvement in health promoting practices in relation to neonatal health. While the association with reduced neonatal mortality has been established, the association between community participation and reductions in maternal mortality is less clear (Bhutta *et al*. 2008, Rosato 2008). Notions of community participation are surrounded by controversies related to who facilitates participation? What mechanisms are used? Is community participation or supply side driven improvement in health facilities more important?

There is enough evidence that future strategies to improve maternal and newborn survival need to integrate community-based organizations and strategies (Rosato 2008). Our study adds to the knowledge about the way BRAC facilitates participation through the MNCH committees. While the effectiveness of the MNCH committee is predicated on increased community participation, in common with other programmes (Jashimuddin *et al*. 2001). Our findings reveal that achieving this kind of community participation is not a simple matter. Many committees exist on paper to raise voice and accountability but remained non-functional due to lack of pragmatic plan and its implementation. At local level there are multiple committees that are facilitated by a variety of BRAC programmes. These include the basic BRAC VO (Mannan *et al.* 1995, Rafi *et al.* 1999, Rashid and Alim 2005), the Water, Sanitation and Health (WASH) Committee (Sharmin 2005, Ali 2009, Kabir *et al.* 2008, Kabir *et al.* 2010), the BRAC School Committee (Sweetser 1999), the Tenant Farmer Village Organization (BRAC undated), and the *Gram Shahayak* Committee (Village assistance committee) (Matin 2004, Rashid *et al.* 2010) and MNCH (Mridha *et al.* 2009). Variously, these committees share the major challenges faced by the MNCH committee – lack of clear technical and procedural guidelines, weak training, limited or no designated financial resources, overlapping membership and duplication of effort within an unspecified local development plan.

It might be that BRAC has taken for granted its foundational principles embodied in the VO. It somehow assumes that health information is being effectively communicated and procedures are functional, with the result that BRAC has failed to effectively train members of these committees, including the MNCH committee, in a way that they are able to act as dynamic agents of change in their communities. This is despite the contextual changes where there are higher proportions of the community who are now literate and a growing number who use telephone, SMS and internet-based communication. Furthermore, there are anecdotal reports that BRAC programme officers are regularly transferred not only from one location to another but also from one programme to another. This potentially limits the way POs can work alongside MNCH committees in an informed, sustained and empowering

way so that committees can in turn, empower other community members to hold service providers to account.

With regard to the irregularity of committee meetings and poor attendance, we suggest that this might be because of overload on small numbers of people who are considered community leaders as they are involved in several committees. It is clear that BRAC personnel select known leaders. Further research is needed to help us understand why BRAC staff make these selections, whether there are alternative models that might be used for selection of community members. We note too that in many areas transport and road networks have improved and community leaders are more likely to be moving around the district towns on other business, and therefore less able to attend meetings.

Despite these ongoing challenges to what we might term, 'facilitation of community participation by committee', our study reveals reports of a few positive changes (improved behaviour and time-keeping) at the local health facility level. However, we noted that these benefits were enjoyed only those who were closely related to the committee members, not for those who lived in remote areas. These interventions by MNCH committee members seemed to be more of an expression of traditional patron-client relationships, and therefore, on the one hand, call into question the capacity of the MNCH committee to empower community members. While on the other hand, even with very limited technical information the MNCH committee meeting encouraged birth planning and effective care-seeking during complication. In this respect, our findings therefore resonate with studies conducted in Nepal where the benefits of raising community voice on neonatal outcomes were well established. In Jharkhand, Orissa and Pakistan where community mobilization through group sessions, significantly increased the rates of skilled birth attendance and facility-based care (Manandhar *et al*. 2004, Rahman *et al*. 2008, Rath *et al*. 2010).

Community members' perceived inclusion of the high status person such as ward member, teacher and *imam*, in the MNCH committee as important. While this needs to be balanced with our findings about the exclusion of those who live in the periphery, we note that committee chairman played an important role to talk with elderly person in the community regarding their traditional views on newborn care. In Bangladesh beliefs and practices about childbirth are deeply embedded in local culture (Afsana and Rashid 2000). Pregnancy and childbirth is normally perceived as a natural matter of women and dealt with in domestic environment (Afsana and Rashid 2000). Once a complication occurs the woman needs to be managed by health services – a public arena. At this juncture men are involved (Afsana and Rashid 2000, Banu *et al*. 2010). There are, therefore, several discourses and diverse knowledge that are brought to bear on decision making (Afsana and Rashid 2000, Banu *et al*. 2010).

Authoritative knowledge is 'knowledge that counts' (Chamber 1997). It is the knowledge that people trust as they make day to day decisions and take action (Davis 1997). Authoritative knowledge is inevitably contested. In the context of MNCH in Bangladesh, there is, first, the tension between women's authoritative knowledge

about childbirth and men's knowledge of the public sphere. Secondly, there are tensions between deeply ingrained, emotionally charged traditional beliefs and practices and biomedical messages and procedures (Hossain *et al*. 2009, Banu *et al*. 2010, Afsana and Rashid 2000, Afsana 2004). Thirdly, the burden of women's household work, lack of freedom for decision-making, mobility restriction, lack of earning opportunities, cultural and social stigmatization, domestic violence all militate against women raising their voices (Afsana 2004). The fourth tension about authoritative knowledge and childbirth emerges from the second and third. Our research has revealed that there is a tension between members of the MNCH committee perceived as 'educated' and less educated.

In South Asia, education carries with it symbolic meaning in relation to social prestige. MNCH committee members who were also community representatives were categorized by health workers as having less education about both the technicalities of MNCH (biomedical messages and practices) (Banu *et al*. 2010) and committee procedural issues. On the other hand, the capacity of junior staff such as modestly educated SKs (who were also community members) to orient MNCH committee members (such as union or ward chairmen) to MNCH issues is limited because, the chairmen along with teachers, *imams* (Religious leader) are inherently higher status persons. Furthermore, gender differentials came into play because the high status community members of the MNCH committees are usually men rather than lower status women. Thus, for example, the SK might know more about safe birth planning and danger signs but the MNCH committee members do not consider her knowledge as authoritative, while the health staff and some community members do not consider the limited technical knowledge of the MNCH committee members sufficient. What is clear from our findings, however, is that where a family knows the MNCH committee member, where a family lives close to the committee member or when a high status committee member comes to their home then the knowledge of the committee member is held as authoritative. Existing patron-client relations operate in the context of the MNCH committee. There are social reasons for poor and vulnerable community members to accept committee member's advice and, at times, their financial assistance. Our findings however, do not reveal any sense of obligation to the MNCH committee members that is felt by those who have benefited from their support. The replication of existing patronage relationships brings into question whether the MNCH committee is needed at all or whether orientation of all community leaders would suffice to communicate health messages to community members. On the other hand, there are real advantages to having certain community members and leaders who are trained and skilled in health communication (including the use of SMS messaging) and in acting as advocates for women and their families within the health system.

The deployment of community people as trained CHWs (SS and SK) offers a mechanism for reaching appropriate health facility when a woman faces an emergency or when a risk factor has been identified (Campbell and Graham 2006, Bhutta and Lassi 2010). Our findings indicate that the MNCH committee strengthened referrals by the SS and SK. These kinds of linkage encourage poor women to receive care and potentially reduce death from preventable causes (Banu

et al. 2010). Although we still need to understand why some families, despite the advice of the SS, SK or MNCH committee member do not go for referral.

Overall, public and private health systems at large are not accountable to meet healthcare needs of marginalized people, particularly the needs of poor women (Hossain *et al*. 2009). Government and NGOs have taken some efforts to improve accountability of health facility staff but the progress is slow due to inadequate resources, wide spread corruption, lack of professionalism and limited knowledge about health rights (CPD 2003). Our findings indicate that the capacity of the MNCH committees to raise the voice of poor people is fairly limited due to inadequate orientation of the committee members, lack of publicity about the role of the committee and therefore lack of strong community organization. Internally at national level, BRAC Human Rights and Legal Aid Services Division considers that health facilities should have, under law, a 'duty of care', that is an obligation to provide services of a specified standard (Pereira, personal communication, 2009). To fail to do so would be punishable. However, at the moment, there is no strategic action in place to advocate the inclusion of this in Bangladesh legislation (Pereira, personal communication 2009). Thus, BRAC has very limited success at increasing the accountability of health service providers nationally and locally. However, it was evident from the study findings that, the MNCH committee strategy was associated to some extent with improvement of MNCH care-seeking and, therefore, to the achievement of the MNCH programme goals and ultimately to the MDGs.

The limitations of this study are that it was a small qualitative study that examined the functioning (at least three meetings held) MNCH committees only. The study was conducted in locations where levels of education rate are low and the community people have limited or no baseline awareness about their health right. It might, therefore, be too early to expect any significant change in terms of quality services, transparency and accountability in such setting. We did not explore the reasons for non-functioning committees although our findings should generate hypotheses that could be tested. Should the MNCH programme decide to modify the ToR and training of MNCH committee members as identified in this report then further research is needed to evaluate their function in large settings.

Conclusion

The study findings show that although the mechanism by which they operate reflects traditional patron-client relationship, MNCH committees have had modest success in motivating and encouraging community members to follow practices recommended for improved MNC health. This was appreciated by all respondents. However, the MNCH committee is not adequately prepared for a more effective behaviour change communication role to play nor, more importantly, for its role in assisting community members to raise their voice to hold health service providers accountable for their performance. This study contributes to the further development of an enabling environment in which the voices of MNCH committee members and community people will be strengthened.

Recommendation and policy implications

Considering the study findings MNCH programme should address the following issues:

- Adjust terms of reference for MNCH committee to ensure that other enthusiastic and devoted community members can be included;
- Develop generic guidelines for committee procedures and ensure members understand the importance of e.g. early notification of date, time and venue of meetings; early production and distribution of minutes to function as a list for action before the next meeting;
- Provide training to MNCH committee members about technical aspects of MNCH, health rights, duty of care due to population by health facilities; communication (including SMS) and advocacy skills;
- Arrange alternate MNCH committee meetings in the periphery where community members can easily attend;
- Increase the publicity about the role of the MNCH committee and the schedule and agenda for meetings. Use word of mouth, simple posters and SMS messaging;
- Occasional attendance at MNCH committee by someone from regional or head office may encourage committee to be more active;
- In village community, both men and women are the key to the improvement of maternal and neonatal care. MNCH committee should maintain close relation with family members of mother and other with other local community organizations to raise community voice and to improve MNCH-related practice; and
- At programme level, consider the incorporation of human rights agenda into programme communication.

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