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# The role of learning from other countries in Bangladeshi health system reform

## The Sector Wide Approach (SWAp) and Community Clinics

## Learning for Action Across Health Systems – Case Study

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# Executive summary

## Objective

The question this study aims to answer is as follows: ‘How do the sector-wide approach and community clinics health reforms in Bangladesh inform the mechanisms of health policy transfer and learning between countries?’ Overall, the collection and analysis of data sought to answer the following sub-questions: 1) ‘How do decision makers at country, state, and province levels access ideas and evidence about how to make their health systems work better and where does international evidence fit in that picture?’, and 2) ‘What gaps do decision makers at country, state, and province levels perceive in their access to appropriate evidence in general, and evidence about other countries' experiences in particular?’

## Methodology

The study was conducted by a senior consultant with in-depth knowledge of the selected country and a research assistant who assisted in data collection and analysis. Two methods were used for the collection of data. First, interviews were held with key in-country policymakers, health officials, and leaders from international organisations. Interviews were scheduled via the Oxford Policy Management (OPM) office in Dhaka. A snowball sampling method was also used, which involved asking respondents to identify other potential interviewees who in their view were important in the process from initial consideration to implementation design.

## Findings

- The donor partners that enjoy strong credibility and influence in the country have successfully facilitated learnings from other countries to initiate policy reforms. The shifting of health sector engagements from project to programme mode (a sector-wide approach (SWAp)) in Bangladesh was preceded by donors (led by the World Bank) presenting examples from Tanzania and Uganda. To succeed, such transfer of policies inevitably requires: 1) a homegrown need; and 2) reform champions in the government at leadership level.
- Reforms often happen in the absence of systematic evidence, provided there is a political need. Though the initial merging of the Family Planning and Health departments under one ‘Sector Programme’, which took a bottom-up approach, did not prove to be a workable model, appropriate positioning of issues for political leadership (e.g. clinic-based services in Bangladesh) ultimately led to acceptance and strengthening of the reform agenda. The concept of community clinics was patronised by political leadership and further strengthened by positioning it as a technical solution for improving the coverage of family planning services, as well as for addressing the broader agenda of catering to the reproductive health of poor women.
- Learning from other countries perhaps happened indirectly, when government officials in Bangladesh made sponsored visits to other countries (Indonesia) to experience clinic-based services. Conferences presenting models to address specific problems also facilitated learning from other countries.
- There was a demand for technical assistance from government at the operationalisation stage of the community clinics, as policy transfer in the context of the country needed substantial support through the donors. Technical assistance is an essential follow-through action needed for evidence-based policies: mechanisms to operationalise the conceptual framework were highly valued by the government staff.

 

## Conclusions

Policy reforms have seldom been based on systematic evidence in Bangladesh and evidence-based policymaking is perhaps an ideal situation that may not resonate well with experiences of reforms in such countries. However, facilitation of learning from other countries by donors and positioning of issues in relation to political need have resulted in early conceptualisation and internalisation. Unless there is a felt need at the country level for a reform, it may be difficult to find champions at the highest level of government, to drive the agenda. 'Isomorphic mimicry' of policies that are successful elsewhere is not expected to generate interest in the recipient country, especially when the social, political, and economic environments do not match with that of the 'good practice' sites. Understanding political needs can also lead to quick reforms through appropriate positioning of the issue, at an opportunistic moment. Lack of an evaluation culture or resistance to conducting evaluations of government programmes are major deterrents to identifying gaps in current practices, which provides an opportunity to external donors to play an important role by demanding such exercises. Although quite a few policymakers are sceptical about evidence preceding policy, windows of opportunity to present learning from other countries are often available for technical, administrative, or political reasons.

## Recommendations

Four key recommendations are presented below to guide the Bill and Melinda Gates Foundation in its future investments in low-income countries:

- Identify the latent needs of the country and areas needing reforms, to engage with donors, government, and non-governmental organisations (NGOs) at country level for a consensus: A major lesson from the Bangladesh case study has been the importance of driving reforms for a need felt at the country level and communicating solutions by sharing learning from other countries. This ensured early conceptualisation and internalisation.
- Identify technical evidence and engage with donor partners at the country level early to create a critical mass of influencers for the desired policy: The Bangladesh case study shows that although World Bank had taken the lead for initiating SWAps in the country, other donors also supported the cause to address the issue of a large number of projects being managed inadequately by limited government staff. Published articles (e.g. by Andrew Cassel) on the positive experiences of SWAps from other countries further strengthened the position of the donors in presenting evidence in favour of such a reform.
- **Identify key reform champions from the highest level of leadership in the government to manage inhibitors**: Reforms inevitably encounter players who are against such changes. It is only through the leadership level in government that such resistance can be managed or lowered below the critical level. Moreover, convincing the political leadership about reforms also requires buy-in from such administrative leadership in the government. In the case of Bangladesh, the senior officers of the government ensured cooperation from different agencies, including Ministry of Finance and staff of the Health and Family Planning units.
- **Evaluate current programmes to understand gaps**: The Bangladesh study revealed that although some evaluations of health sector programmes carried out by NGOs exist, they were not considered by policymakers in relation to reforms. Full-scale evaluations of health programmes by large donors could provide important information on gaps, which could lead to positioning of evidence from elsewhere for learning, and consequently reforms.

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# List of abbreviations

| | |
|---|---|
| ADB | Asian Development Bank |
| BRAC | Bangladesh Rural Advancement Committee |
| CDC | Centres for Disease Control |
| CHCP | Community Health Care Provider |
| DFID | UK Department for International Development |
| DGHS | Directorate General of Health Services |
| EBP | Evidence-based policy |
| ESP | Essential Services Package |
| FWA | Family Welfare Assistant |
| GNI | Gross national income |
| GOB | Government of Bangladesh |
| HNP | Health, Nutrition, and Population |
| HNPSP | Health, Nutrition and Population Sector Programme |
| HPSP | Health and Population Sector Programme |
| icddr,b | International Centre for Diarrhoeal Disease Research, Bangladesh |
| MDGs | Millennium Development Goals |
| NGO | Non-governmental organisation |
| OPM | Oxford Policy Management |
| STI | Sexually transmitted infection |
| SWAp | Sector-wide approach |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

# 1 Introduction

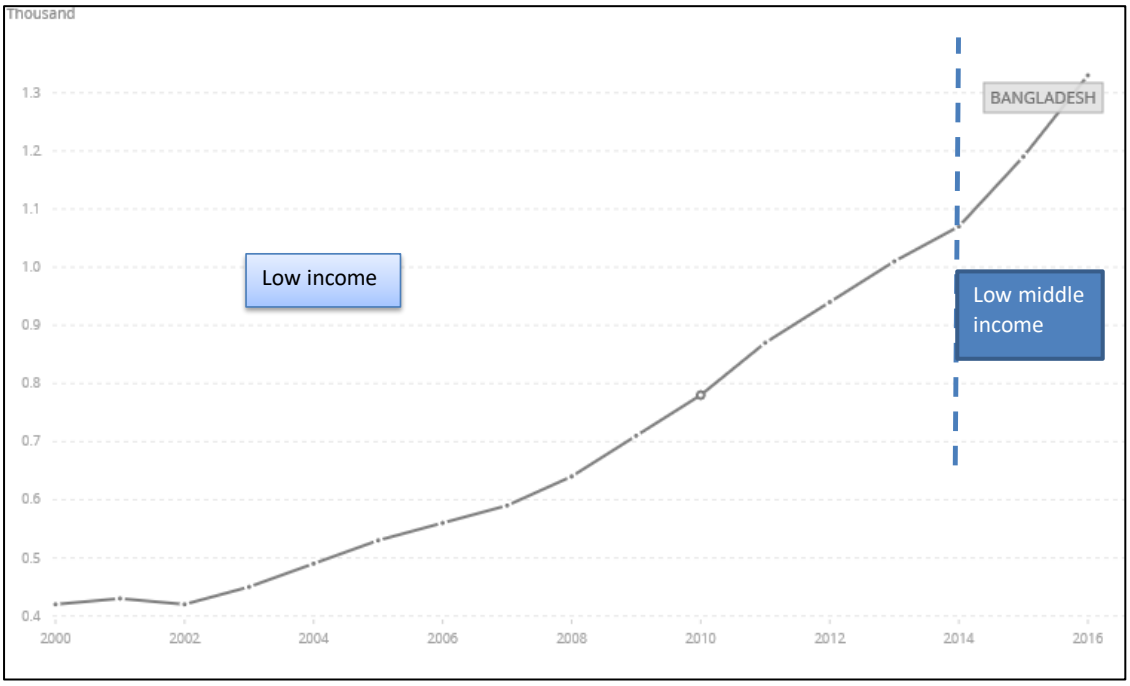
## 1.1 Country selection criteria

Bangladesh was chosen for this case study because it meets the following four criteria:

1. the country was categorised as low-income in 2000;
2. it has made substantial economic progress until 2017, measured by gross national income (GNI) per capita;
3. it has a record of good performance in achieving Millennium Development Goal (MDG) outcomes in health and nutrition; and
4. OPM has an office to assist in the data collection required to pursue the study.

Bangladesh was a low-income country until 2013, with a GNI of US$1,010 per capita.[1] It graduated to a low-/middle-income category in 2014 (refer to Figure 1 below) and was categorised as a 'less indebted' country by the World Bank. The percentage of the population living under the poverty line has decreased from 48.9% in 2000 to 31.9% in 2010 (World Bank 2017).

**Figure 1: Bangladesh's GNI per capita (US$)**




Bangladesh has also made substantial progress on improving health and nutrition outcomes in the last decade. Since independence in 1971, Bangladesh has achieved impressive improvements in population health status and has achieved MDG4 (WHO, 2017)[2] by reducing child mortality before the 2015 target (refer to Figure 2), receiving a UN award for this in 2010. It has also improved on other key indicators, including MDG5 indicators, such as maternal mortality and survival from some

[1] As per World Bank Country Data, a country is categorised as low income if GNI per capita is less than US$1045 (2013 value).
[2] Includes reducing by two-thirds, between 1990 and 2015, under-five mortality rate, infant mortality rate, and proportion of one-year-old children immunised against measles, as per WHO.

infectious diseases, including malaria, tuberculosis, and diarrhoea (World Health Organization (WHO), 2015).

**Figure 2: Progress on MDG4 indicators in Bangladesh from 2000-2014 (US Agency for International Development (USAID), 2017)**

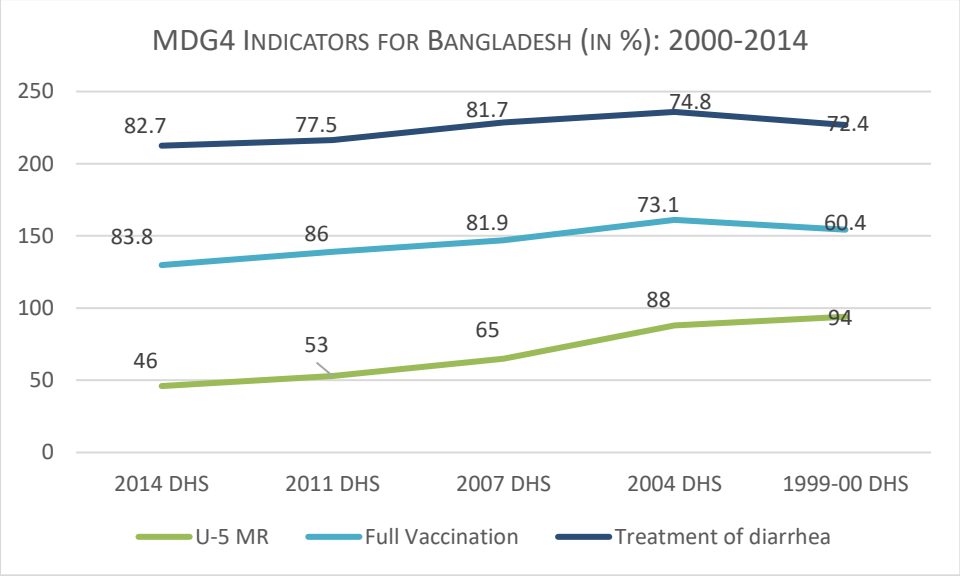
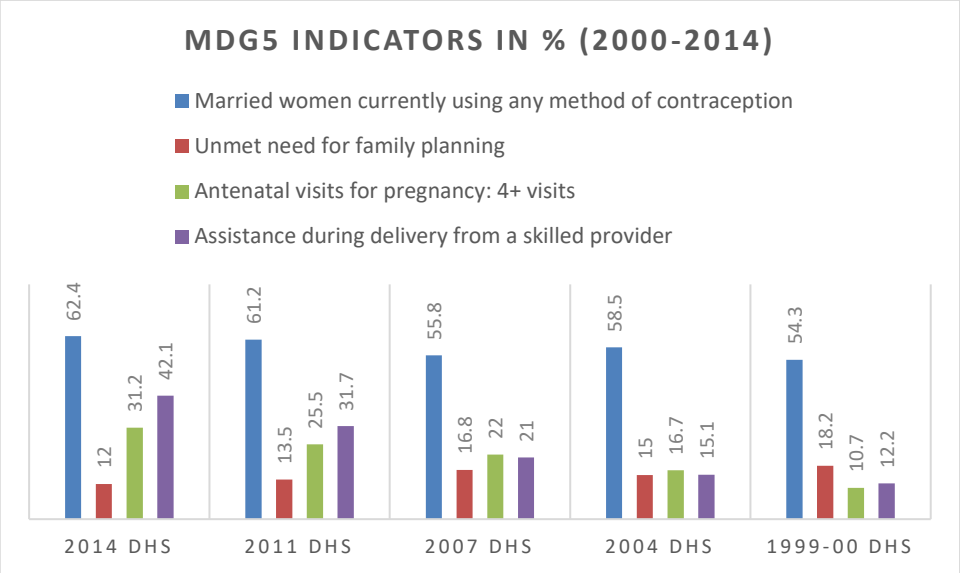



**Figure 3: Progress on MDG5 indicators in Bangladesh from 2000–2014**




OPM has a strong presence and substantial experience of working in Bangladesh. The principal investigator for this assignment also has many years of experience of working in south Asia and Bangladesh. Thus, Bangladesh satisfied all four criteria decided for this study.

## 1.2 Identification of 'tracer' reforms

Since independence, Bangladesh has focused mainly on health services in rural areas and the development of a network of healthcare facilities, starting with the First Five Year Plan (1973–78). Following a comprehensive review of the Fourth Population and Health Project (1992–98), concerns were raised about the lack of progress in reducing maternal mortality and morbidity, the

low utilisation of government health services, their cost-effectiveness, and the sustainability and quality of such services (Islam and Biswas, 2014).

The National Health Policy was formulated in 2000 after reform initiatives were included in the first health sector SWAp in 1998. The consultants of this study aimed to understand the basis on which these reforms were planned and implemented, how widespread changes in institutional mechanisms were accepted, and whether evidence from other countries affected these changes.

Recent health sector reforms in Bangladesh commenced with the Health and Population Sector Strategy developed by government and donor partners in 1997 (WHO, 2015). The Bangladesh Health Systems Review notes that the strategy recommended a number of institutional reforms, 'notably the shift from a project basis towards a coordinated sectoral programme'. This resulted in the pooling of donor funds through a SWAp during the first Health and Population Sector Programme (HPSP) from 1998 to 2003. The document also refers to the introduction of one-stop services through Community Health Clinics to replace domiciliary services provided by family planning services field staff. Establishment of these clinics started in 1998, heralding a major shift in family planning services, from door-to-door to clinic-based, but were abandoned in 2001 with a change in political power. The clinics were revitalised in 2009 after the political party that patronised the initiation of the clinics won the elections and the government changed (refer to Box 1).

**Box 1. Reforms in the health sector of Bangladesh**

Under HPSP (1998–2003), measures had been taken to restructure the entire health system to make it more responsive to the health needs of the population.

…Resources were allocated to those facilities and services (Upazila and below level facilities) that were most needed and used by the vulnerable groups. Since 2009 the newly elected government undertook a massive effort to establish Community Clinics at the village level (1 Community Clinic for every 6,000 population) with a view to bring services to the doorsteps of the people at large. At the same time, since the second half of the 1990s, issues such as pro-poor focus, community participation and empowerment, accountability, public private partnership for service delivery and demand-side financing gained momentum. Consequently, the structure and the service delivery model of the publicly-funded health system underwent profound changes.

*Extracted from: Health Systems in Bangladesh: Challenges and Opportunities (Islam and Biswas, 2014)*

In January 2003, separate organisational structures and authorities for health and family planning were re-established in the form in which they had existed before July 1998. In 2003, the Health, Nutrition and Population Sector Programme (HNPSP) was created to meet the challenges posed by the International Conference on Population and Development. The HNPSP aimed to reform the health and population sector with the provision of a package of essential and quality healthcare services that were responsive to the needs of the people, especially those of children, women, the elderly, and the poor (Ministry of Health and Population Control, 1985; Mabud, 1992).

Other key reforms included provision of primary care services through Essential Services Packages (ESPs) and the unification of the Health and Family Planning department at sub-district levels. International and national gender equity advocates played a key role in bringing some, though not all, sexual and reproductive health issues, including prevention and treatment of sexually transmitted infections (STIs), menstrual regulation, maternal and child health, and family planning, into the forefront ESP (Murthy and Klugman, 2004). The shift from a project to a programme mode has continued until today, and, as has been said, while community clinics were temporarily closed with a change of government in 2003, they were reinvigorated in 2009 when the earlier political party (Awami League) came back into power in 2009. Health sector reforms in other countries, including India, Pakistan, the Philippines, China, and Cambodia, have not promoted horizontal integration of services, but rather have implemented the integration of activities or

administrative systems or functions. Unlike Bangladesh, in none of these countries was integration a key element of reform, but was one of several components (Murthy and Klugman, 2004).

A literature search and responses from an initial workshop conducted by OPM in Dhaka in August 2017, with participation from academia, ex-government officers, NGOs, and development partners, further emphasised the commencement of SWAps and community clinics as major reforms shaping the present health system, with political economy emerging as a key criterion influencing these over the years. Accordingly, the team selected these two as the major reforms for further study.

## 1.3 Literature review

This section seeks to provide a background and brief overview of key debates and issues within the primary topics of this study. Literature is reviewed on SWAps and community clinics, in relation to which empirical research in the context of Bangladesh is lacking. The literature reviewed provides useful internationally- and in-country-sourced discourse and outcomes from policy and practice.

### 1.3.1 SWAps

The starting point for SWAps is often attributed to a paper published by Cassels in 1997, who defined the objectives of SWAps as follows: 'To achieve sustained improvements in people's health and well-being requires long-term partnerships in which development assistance is used to support nationally defined policies and strategies. Sector-wide approaches (SWAps), organized around a negotiated program of work, offer a better prospect for success than the piecemeal pursuit of separately financed projects.' (Cassels, 1997: 9). This document, published by the WHO, defined key tenets of SWAp to include shared goals between government and donors, as well as donors' willingness to give up decisions regarding the selection of projects in exchange for developing sector-wide strategies. Another initial paper explained that the goal of SWAps is to push the development of reforms on to domestic processes while ensuring the sustainability of those reforms. SWAps may not be appropriate if a government does not intend to take leadership, when the purpose of the reforms are to achieve political gains, or to fund short-term humanitarian assistance (Peters and Chao, 1998).

As SWAps were implemented, their focus remained on improving efficiency via different types of relationships between government and donors, while they increasingly became intertwined with poverty reduction and achieving the MDGs (HLSP, 2005). Initial challenges that were observed when SWAps were first established included negotiations between government officials and donor representatives on issues of funding – for instance the funding of tertiary hospitals. In response, negotiation processes became regular parts of SWAp implementation and were regarded as necessary in order to reach compromise between parties (Peters and Chao, 1998). As SWAps continued to be used, they were seen as facilitators of the development of national policies, transparent expenditure plans, and strengthened in-country capacity. However, experiences and outcomes varied widely among countries (Peters *et al*., 2013).

The literature has identified various challenges that countries with SWAps have experienced regarding factors that hinder their projected improvements in efficiency. Firstly, there has not been a SWAp to which all donor partners in a country have contributed. Organisations such as President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund continue to drive policy through their own networks and programmes rather than participating in pooled funding (Peters *et al*., 2013). This, in combination with largely inconsistent roles for donor, government,

and private sector actors, results in inadequate recognition of the broader needs of the health and policy communities in which those programmes operate.

A year 2000 study of five countries that implemented SWAps found no evidence to suggest that SWAps help resolve politically sensitive issues, and revealed limited participation among donors, and inadequate monitoring and evaluation (Foster *et al*., 2000). They also found, however, that SWAps were increasingly becoming better integrated with in-country budget processes, links between policy and implementation were becoming more effective, governments were using SWAps as an avenue to strategise for sector-wide instead of project-specific health approaches, and donors had forums through which they could voice their concerns. Additional studies have been conducted to assess the development of SWAps in Malawi, Zambia, Tajikistan, Samoa, Solomon Islands, and Uganda (Bowie and Mwase, 2011; Leiderer, 2013; Mirzoev *et al*., 2010; Rechel and Khodjamurodov, 2010; Negin, 2010; Orinda *et al*., 2005). Recommendations for improving SWAps include improving evaluation and using outcomes as measures to assess needs and/or conditions of future funding (Garner *et al*., 2000; Goodburn and Campbell, 2001).

Bangladesh adopted a SWAp to health in 1998. Sundewall *et al*. observe that while ownership and coordination have been accepted in Bangladesh, these processes have not been formalised (2006). Because of the far-reaching effects the SWAp has on health system development in Bangladesh, as well as the significant involvement of international actors in this reform, this study will assess how the SWAp in Bangladesh informs processes of policy transfer in low- and middle-income countries (LMICs).

### 1.3.2 Community clinics

The objective of community clinics is to provide a number of primary care, counselling, and referral services to villages in rural areas. Community clinics largely depend on the participation of community members who manage community groups and community support groups. Community groups consist of elected local government representatives, and manage the operations of clinics. Community clinics are largely conceptualised as a successful form of public–private partnership due to the involvement of local people and the donation of private lands for the building of clinics (WHO, 2015). Published information on community clinics is largely not empirically based, nor does it include either peer-reviewed studies or independent evaluations. Existing reports that were found are sourced from either government health officials or donor partners. Two reports were identified from international organisations, including one from SPRING (2015), a USAID-funded NGO, and one from the WHO (2015). Both of these reports highlight anecdotal outcomes from a small number of high-performing clinics. Two presentations were gathered from government health officials, one from 2014 and one from 2017, that summarise key aspects of how community clinics function. However, they offer limited information on the outcomes or challenges of clinics thus far.

Community clinics were first implemented in Bangladesh in 1998. Between 1998 and 2001, 10,723 clinics were constructed and 8,000 started functioning (Nargis, 2014). The goal was to establish one clinic for every 6,000 people within a half-hour walking distance from their households. A change in government, or what the WHO describes as ‘logistical reasons’, in 2001 led to the discontinuation of funding for clinics. However, since the revitalisation of clinics in 2009, with the government aiming to operationalise 18,000 clinics, it is reported that 12,901 clinics were operating in 2015, with each clinic receiving an estimated 40 patients each day (WHO, 2015: 2). Clinics provide primary-level care through three types of service providers: Community Health Care Providers (CHCPs), Health Assistants, and Family Welfare Assistants (FWAs). Services that are available at clinics are reported to include maternal and neonatal services, integrated management of childhood illness, reproductive health and family planning, nutritional education and micro-nutrient supplements, health education and counselling, screening of chronic and non-

communicable diseases, treatment of minor ailments, first aid, and referrals to higher facilities (Nargis, 2014). A 2014 government report cites lessons learned as the need for the involvement of community groups and regular supervision and monitoring (ibid.).

Both presentations from government officials in 2014 and 2017 cite partnerships with NGOs and donor partners as being integral to achieving the success of community clinics. In 2014, three development partners and 14 NGO partners assisted with the development, training, financing, and monitoring of community clinics (Nargis, 2014). The 2017 report expanded the value added of NGOs to include the strengthening of community groups, capacity development, data digitalisation, and identification and referral (Yousuf, 2017). The WHO itself has been involved in the development of training manuals, training of trainers, and piloting of clinics (WHO, 2015). SPRING has also assisted with training and development, specifically in the dissemination of trainings on nutrition and hygiene to CHCPs, Health Assistants, and FWAs. SPRING works in 40 Upazilas (sub-divisions) and reports it has trained 4,500 health workers in nutrition and hygiene (SPRING, 2015). Both the WHO and SPRING describe clinics that are well-utilised, accommodating to patients, and effectively providing health services. However, there is much information that is unknown about the implementation and outcomes of community clinics. Along with the SWAp, this report examines the development of community clinics as a policy in Bangladesh and its implications for learning between countries.

# 2 Methodology

## 2.1 Approach

The question this study aims to answer is as follows: 'How do the SWAp and community clinics health reforms in Bangladesh inform the mechanisms of health policy transfer and learning between countries?'. This study complements interviews that have been conducted with in-country policymakers and health practitioners in Burkina Faso, Cambodia, Ethiopia, Georgia, Nepal, Rwanda, and Solomon Islands to understand how cross-country learning takes place for the purpose of health systems strengthening. Prior to the interviews in Bangladesh, three landscaping reviews were conducted to understand comparative health systems literature that includes empirical analysis, platforms that currently exist where countries can learn from one another as they undertake health system reform and strengthening, and processes of policy transfer in LMICs.

Overall, the collection and analysis of data sought to answer the following sub-questions: 1) 'How do decision makers at country, state, and province levels access ideas and evidence about how to make their health systems work better and where does international evidence fit in that picture?', and 2) 'What gaps do decision makers at country, state, and province levels perceive in their access to appropriate evidence in general, and evidence about other countries' experiences in particular?' The final recommendations of this case study aim to examine the mechanisms that are currently being used which may be further strengthened by investment and the spaces for new initiatives.

## 2.2 Data collection and analysis

The study was conducted by a senior consultant with in-depth knowledge of the selected country and a research assistant who assisted in data collection and analysis. Two methods were used for the collection of data. First, interviews were held with key in-country policymakers, health officials, and leaders from international organisations. Interviews were scheduled via the OPM office in Dhaka. A snowball sampling method was also used by asking respondents to identify other potential interviewees who in their view were important in the process from initial consideration to implementation design. Interviewees' background and current position held within public agencies and/or NGOs were considered. Identification of respondents was facilitated by relationships between the Country Director of OPM's Dhaka office and various government ministries and private entities related to health programmes in Bangladesh.

Overall, 13 individuals were interviewed. Interviewees included senior civil servants in health ministries, senior health advisers in non-governmental agencies and civil society organisations, and academics. Respondents were selected according to their relevance to the topic, specifically their potential to provide information concerning the two reforms selected, the SWAp and community clinics. All interviewees had influenced or were impacted by the reforms during the time they were being formulated or implemented. Their positions and organisations are listed in Annex B.

Interviews were semi-structured and were based on a pre-formulated guide. The guide focuses on six stages of policy development, namely conceptualisation, formation, internalisation, contextualisation, operationalisation, and evaluation. These stages were identified in a scoping review written prior to the in-country interviews, the goal of which was to understand the mechanisms through which policy transfer takes place (McPake *et al*., 2017). The guide focused on how policy was developed throughout those stages, with an emphasis on the type of evidence that was used, the perspectives of decision makers, the knowledge of interviewees about the

processes of using evidence, and methods for sharing evidence. The guide also included probing questions which the researchers could choose to employ if appropriate. Interviews were not audio recorded due to the politically sensitive nature of the reforms in question; however, notes were taken via laptop.

Second, a workshop was held in Dhaka to further understand the development of the SWAp and community clinics health reforms. Attendees of the workshop were a mix of policymakers and health practitioners from public agencies, NGOs, and universities. An effort was made to include experts from a variety of sectors, from government to civil society and academia, as well as experts who were involved in the development of policy (in designing or implementing the reforms) at different periods of time. The workshop was an environment in which ideas could be presented and debated in a group, allowing the researchers to gain a better understanding of the perceptions and roles of those involved in the development of the SWAp and community clinics, from when they were first being conceptualised to present-day implementation. The workshop consisted of an initial presentation of the objectives of the overall research and goals of the workshop itself, small group discussions in which groups focused on specific reforms and were asked to respond to questions concerning the reforms' development, a large group discussion in which participants shared their conclusions and were able to respond to others, and a writing exercise in which participants summarised outcomes of the workshop. The written questionnaire, key findings from the workshop, and a list of attendees can be found in Annexes B, C, and D, respectively.

Data analysis considered the findings of interviews and the workshop with respect to the goals of the study: to assess how the SWAp and community clinics health reforms in Bangladesh inform the mechanisms of health policy transfer and learning between countries, as well as in the context of the broader aim to identify specific opportunities for learning between countries. Analysis of the findings considered how interviewees positioned themselves in relation to the six phases of policy transfer, use of evidence throughout the development of the reforms, perspectives on what helps and hinders learning from the experiences of other health systems, institutions and mechanisms that facilitate policy transfer, and implications for future investment in opportunities for cross-country learning.

## 2.3 Ethical considerations

In most respects, the process involved in collecting the knowledge and perspectives of participants raised few ethical concerns. However, an important ethical concern arose from the tension between the study's objective of collecting accounts and opinions on politically sensitive reforms and the risks to individuals of such views being published. Therefore, we use Chatham House rules, which allow for participants to be acknowledged but specific comments and opinions to be kept un-attributable to the individual from whom they were collected. Interviewees were advised of these procedures when they consented to the interviews. We did not require written consent to interview as this tends to foster suspicion and concern about the official nature of the interview, and the legal implications of a signature, rather than reassurance.

# 3 Results

## 3.1 Positioning of interviewees in relation to policy transfer

Interviewees primarily provided perspectives on either the conceptualisation and operationalisation stages of policy transfer. Most interviewees who provided insight into conceptualisation were formerly decision makers in the Ministry of Health and Ministry of Family Welfare. Formation of the policies was observed by the respondents; however, the information gathered from interviewees about the formation of the SWAp and community clinics was mostly second-hand – most interviewees observed rather than were a part of those processes. Internalisation and contextualisation were not specifically mentioned by the interviewees as processes related to the development of health reforms. However, a small number of respondents currently involved in the implementation of health policy did allude to processes in which evidence was used to 'internalise' and 'contextualise' lessons learned from other countries. Most respondents provided their perspectives on the operationalisation of the reforms, perhaps since operationalisation is a more visible process than others and since several interviewees were involved directly or indirectly in the implementation of the SWAp and community clinics. Respondents mentioned the need for evaluation more often than evaluations that have been undertaken, with a couple of exceptions in which interviewees mentioned external evaluations – however, in these cases they were not able to provide specific details of how those evaluations were conducted or their impact on subsequent development of policy.

## 3.2 Conceptualisation

Key drivers facilitating the conceptualisation of tracer reforms were either donor requirements or political needs, supported by the leadership in government. In-depth discussions with interviewees who were ex-policymakers revealed two different processes for the conceptualisation of the SWAp and community clinics. The main reasons cited for a shift from a project to a programmatic mode of support to the health sector in 1998 were large transactions costs and inefficiencies associated with more than 120 standalone projects, each supported by various donors. With limited government staff handling these projects and each donor maintaining different requirements, the process of managing and extracting information from these projects became extremely inefficient. Donor partners, led by the World Bank, recommended a SWAp, with a common framework of support for all donors, as a major solution to this problem. SWAps supported by the Bank in Tanzania and Uganda were cited as relevant examples, which the leadership in government administration in Bangladesh accepted.

One interviewee mentioned a specific article written in 1995 concerning the importance of health sector reform. While this article does not outline steps for SWAps to reform, it does recognise the need for creating more efficiency in donor aid while reforming in-country budget and accountability systems (Cassels, 1995)[3]. The 1994 International Conference on Population and Development in Cairo and 1995 UN Fourth World Conference on Women in Beijing advocated for an integrated approach that would include health services, family planning, and women's empowerment, as an ideal approach for dealing with continued health and population problems (Normand *et al*., 2006). The 1995 meetings are cited by a few respondents as the turning point in donor partners' approach to health system financing. Although concerns were expressed about whether the SWAp would be successful, primarily from civil society and academics, the reform was implemented regardless.

[3] Cassels did publish subsequent articles dealing specifically with SWAps for health, which may have later impacted the formation of reform policies (Cassels, 1997; Cassels and Janovsky, 1997, 1998).

One respondent attributes this to the fact that the SWAp was largely a donor-driven effort, alluding to competing interests aside from the concerns of these stakeholders.

The following table shows the total amount of funds included in Bangladesh health SWAps from 1998 to 2016, along with contributions made by the Government of Bangladesh (GOB). Total funding has increased, as well as the GOB's proportionate funding (World Bank 2005; 2011; 2012). The increasing proportion of contributions from the GOB shows increasing in-country financial capacity and sustainability, and demonstrates the significant influence that the international aid community had when the SWAp was first introduced.

**Table 1: Contributions of GoB in Health Sector Programmes**

| Programme name | Duration | Fund | GOB contribution | Co-financiers |
|---|---|---|---|---|
| **HPSP** | 1998–2003 | US$2.2 billion | 62% | World Bank, Canada, Germany, Netherlands, Sweden, United Kingdom, and European Union |
| **HNPSP** | 2003–2011 | US$5.4 billion | 67% | World Bank, Canada, Germany, Netherlands, Sweden, United Kingdom, European Union, and UN Population Fund (UNFPA) |
| **Health, Population, and Nutrition Sector Development Programme** | 2011–2016 | US$7.7 billion | 76% | World Bank, Canada, Sweden, Australia, United Kingdom, Germany, and United States |

**Positioning of issues by the government and donors often influences the political agenda.** On the technical front, domiciliary services being provided by family planning functionaries at sub-district level were seen as an inferior model to clinic-based services and this 'positioning' perhaps influenced the political agenda to form community clinics at the village level. The country at that point was looking for options to increase the coverage of family planning services, provided door-to-door by outreach workers. The 1994 conference in Cairo urged countries to focus on more than just contraception and emphasised the need for larger reproductive health interventions, advising against relying just on domiciliary services. While the influence of such recommendations on future policies in Bangladesh is not clear, the Family Planning unit (previously providing domiciliary services only) was merged with health services at the Upazila or sub-district level against the former's will, at the behest of the Ministry of Health and Family Welfare. There was a suggestion at the time that satellite clinics (eight clinics per union at the time) should start working with health outreach workers (24 outreach workers per union) to combine the benefits of fixed facilities with door-to-door services. So, community clinics, though not originally envisaged as the solution to this Upazila-level merging of health and family planning, were perhaps reflected in the original SWAp planning documents as an afterthought. Clinics were not, however, included in the SWAp budget.

**Ideas that originated from political leadership can be more easily implemented even if there is no prior evidence.** Most respondents agreed that community clinics were the 'brain child' of top political leadership at the time, and was technically strengthened later as a model to provide clinic-based services to the rural poor closer to their homes. One interviewee who was involved in the formative stages of community clinics, however, noted that community clinics came about from a very different process to that which had been highlighted by the rest of the respondents. Two respondents mentioned that in the light of scepticism around whether community clinics would effective given they had not yet been proven to be a credible model, they were implemented after the World Bank and other donor partners agreed to include planning for community clinics in the SWAp. Nevertheless, even though the strong patronage of the political leadership in the

development of community clinics cannot necessarily be concretised in evidence, the impact of that support, largely because of the socio-political environment into which community clinics were formed and contextualised, was an important factor in the implementation and continued maintenance of clinics.

The SWAp and community clinics demonstrate that even though donor partners have significant influence on the conceptualisation of policy, health policy reform is entirely dependent on the motivations, circumstances, and value added of government officials. The two factors that contributed to the conceptualisation of the SWAp and community clinics were: 1) the role of key decision makers, such as the Prime Minister, and 2) the identification of a need for health policy reform in response to the high transaction costs created by a project-based approach to health financing and inadequate service provision in rural areas. Therefore, the main trigger for the shift from project to programme mode was need-based and was pushed by external partners seeking better institutional efficiencies, while community clinics were conceptualised more as a tool by which to achieve political benefit while utilising the concept of an 'alternative mode' of clinic-based services discussed by the donors.

## 3.3 Formation/contextualisation

Although systematic evidence from other countries may not have influenced the formation of the SWAp and community clinics, examples cited by donors in African countries addressing the institutional efficiencies expected from such changes may have had an indirect effect. Similarly, some respondents recollected that visits to Indonesia by government officials, funded by USAID, could have played a role in building tacit support for the concept of community clinics. Due to the lack of evidence in general, however, the extent to which the formation of reforms can be attributed to evidence from other countries cannot be readily observed.

Some government officials who were interviewed referred to the value of using evidence from other countries, but clarified that it is the role of international organisations, and not government, to initiate cross-country learning. One respondent said: 'the conditions for cross-country learning are not here because these initiatives [the SWAp and community clinics] were started by the Bangladesh Government. When outside actors come in, it's their responsibility to implement their programmes and export them elsewhere.' Since January 2017, with the introduction of the most recent SWAp, for example, community clinics were included in pooled funding, along with Upazila- and union-level health facilities. After community clinics were included under the SWAp, there was some reluctance from donor partners to fund the current version of the clinics, and these partners have started to look at models of community-based clinics that are established in Thailand and Singapore. International agencies are therefore effective in promoting international evidence.

As such, there has been significant involvement from donor partners and NGOs in the formation and contextualisation of health policies in Bangladesh. The formation of community clinics during the Awami League government was largely assisted with financial and technical assistance from the WHO, which also assisted in the development of training manuals for CHCPs. NGOs such as the Bangladesh Rural Advancement Committee (BRAC), for example in their advocacy in partnership with medical associations in support of reducing complications in home-based deliveries, also have a role to play in evidence generation. In addition, studies on consumer preference in Bangladesh have showed that people supported the establishment of one-stop services (Hasan *et al*., 1997).

## 3.4 Internalisation

Internalisation was not identified by respondents as a separate process, but it appears to have been influenced by donor partners and relied substantially on government motives and the political and economic circumstances in which the reforms were developed. The strong voice of donors, which contributed a relatively high share of finances for the country's health sector projects at that time, an inclination by government leadership to make substantial changes to health outcomes, and their ability to convince the then political leadership of potential benefits, have all been identified as possible causes for 'internalising' the shift to the SWAp. Community clinics, on the other hand, were more driven by political leadership than by other players.

Donor partners are still an active and influential voice in health sector planning, and respondents from large partners expressed their crucial role in addressing the failures of the Government of Bangladesh to organise and provide health services. However, public sector respondents were clear that the government allows them to act as influencers. One respondent explained that rather than government officials being *subjected to* the influence of donor partners, government *allows* the continued involvement of partners in discussions around strategy and reviews of activities. Specifically, 'the government allowed [a] huge invasive presence of donor partners' and 'makes room for' the participation of donor partners: for instance, through task groups in which partners are involved in day-to-day activities of government, and consultation groups that operate at the secretariat level.

Debates between donor partners and the GOB after the SWAp was implemented demonstrate how a largely externally-supported reform is appropriated and owned by internal government interests. Discussions concerning the intent to unify the directorates of health and family planning in the early 2000s led to a breakdown in the original SWAp led by the World Bank in 2001–2003. According to one respondent, donor partners felt that the government had gone back on their promise to unify. In 2005, donor partners were interested in working together again, but the government insisted on maintaining ownership over the goals for health system development. As expressed by one respondent, 'it's the government's privilege to choose their own policy priorities'. From the perspective of donors, there is therefore a need to continually align goals between stakeholders as the frameworks for planning and implementation of a reform are developed and refined.

A majority of respondents noted that there was no opposition to the introduction of the SWAp. One respondent, however, noted that various bureaucrats were initially opposed, and still slightly uncomfortable, with the amount of strategic and planning authority that the SWAp gives to the Ministry of Health. Some of the power for planning and allocation of resources, as well as approving and revising programmes, therefore was shifted from Planning Commissions to the Ministry of Health. Not all donor partners have always been on board, either. USAID, whose yearly contributions are larger than the UK Department for International Development's (DFID's) and almost as large as the World Bank's budget in Bangladesh, as noted by one respondent, has only participated in the third SWAp. Moreover, their participation was largely driven by the Obama administration's goal to invest directly in sovereign governments.

These experiences of internalisation suggest that reforms still occur whether there is agreement or not. However, collaboration and agreement between stakeholders, specifically between key decision makers such as the Prime Minister, is an important factor of policy transfer and is necessary for efficient implementation of reforms.

## 3.5 Operationalisation

**The SWAp may have been influenced by learning through donors about SWAps in other countries, notably Tanzania and Uganda.** As noted above, donor partners have recently observed community clinics in Thailand and Singapore, now that community clinics are included under the SWAp (as of January 2017). Respondents had varied amounts of information with regards to the evidence that is used in the operationalisation of policies.

Evidence seems to be used most effectively when policymakers communicate a pre-identified need in health policy and practice to donor partners and NGOs. With regards to programme implementation, respondents generally preferred international agencies such as the WHO to provide technical assistance rather than high-level planning. This provides external stakeholders with a specific point of entry when collaborating with policymakers and promoting the use of evidence in policy. Although donor partners are often involved in the strategic planning for health policies, the operationalisation stage benefits more from technical and programme assistance. One respondent stated: 'I prefer the life cycle approach developed by the Bangladesh Government rather than the WHO's steps for health processes because it is closer to the real world… [we] need technical support'. The respondent also argued that collaboration with stakeholders is more efficient when policymakers identify specific needs for evidence, saying: 'each organisation has a mandate and I have a mandate, so we need to determine who is helping us in which area'.

The importance of alignment of goals, collaboration, and continuous discussion between stakeholders was highlighted by the operationalisation of the SWAp and community clinics. Both the government and donor partners have established parallel health programmes, for instance, that exist outside of the SWAp, since each entity wants increased ownership over these programmes and the SWAp largely inhibits fast decision making or implementation of programmes at short notices. One respondent noted this as the reason why the GOB operates health programmes outside of the SWAp, largely due to the formalities a government agency has to go through in order to approve funding through the SWAp. This represents a shift from the originally created SWAp, in which donor partners agreed that all implementing entities should agree on the planning and review of programmes, whether they were involved in pooled funding or implementing parallel programmes. The goal of this process was to improve the efficiency of planning and reduce recidivism in policy issues. However, there was gradually a shift away from this approach, both from the government and various donor partners. Improved collaboration may have improved the efficiency of the SWAp by establishing mechanisms for more immediate programme implementation when necessary. Collaboration between government agencies is also needed. As one respondent noted, although there has been a consistent interest in the SWAp on the part of government, the process is largely dependent on the Ministry of Finance rather than the sectoral department. Many respondents highlighted that 'different interest groups and priorities of the government' was one cause of misalignment between the ministries of health and finance, which is why 'budgetary contributions do not reflect [the health sector's interests or commitments]'.

Political economy was the key driver for operationalising community clinics, even if there was no prior evidence of success for such models. As one respondent noted, 'unless there is a homegrown requirement, you can't have a new policy run for a sustainable amount of time'. After a shift in government in 2001, public funding for community clinics was discontinued, and various organisations stepped in to run clinics through their own programmes. Plan International, USAID (through Smiling Sun), and a DFID-run consortium were all involved in community clinics during the period when there was a lack of government oversight of the clinics. When the Awami League government returned, community clinics were once again publicly organised. There was an option at that time to contract the NGOs that were currently running clinics; however, there were political incentives to establish clinics and demonstrate that health programmes were being implemented

for the benefit of Bangladeshi people. Community clinics remained outside of the SWAp since they were continually conceptualised as a government-led initiative, championed by Bangladeshi health officials.

## 3.6 Evaluation

Respondents generally agreed that although some research and inquiry has been undertaken in the health sector, there is overwhelmingly a lack of systematic evidence. Although a few respondents noted that policymakers should understand the value of evidence in policy, there are other factors that affect evaluation, including involvement from programmes themselves, as well as political factors. When answering why there has been a lack of research in Bangladesh health systems, one respondent said that while there are researchers who want to examine health programme progress in Bangladesh, programmes are not always willing to be evaluated. Another respondent mentioned that leadership within the Ministry of Health has largely been politically aligned with the Prime Minister, which means that internal evaluators are hesitant to challenge their programmes. There have been reports on community clinics, however they are scattered and not of very high academic quality. The government itself has its own evaluation unit in the Ministry of Finance, the Inspection, Evaluation, and Monitoring unit. They have done their own evaluations. However, as one respondent mentioned, these have been mostly self-serving studies and are not critical. Although NGOs, such as Plan International, have carried out pilot programmes to understand how community clinics are working, the Directorate of Family Planning has not taken steps to evaluate community clinics or amend their policies.

**Due to inadequate evaluation, conflicting opinions exist about the success of reforms.** Some respondents concluded that community clinics have been highly successful in bringing health services to rural communities and referring patients to other health services, while others highlighted their failures in adequate provision. One respondent stated that the results of community clinics are not consistent with the amount of money being invested and that CHCPs are not adequately trained. Another respondent mentioned that most CHCPs are involved more in desk work than working directly with patients, that community clinics are being used more for access to drugs rather than to receive services from CHCPs, that treatment is not being diagnosed properly, that there is a lack of training and certification for CHCPs, and, regarding the state of evidence, that ‘we have anecdotes, but not evidence’.

Similarly, literature on the Bangladesh SWAp is largely limited to anecdotal information about the outcomes of the SWAp. However, respondents generally feel that the SWAp has promoted government ownership over health programmes. One respondent mentioned that outcomes of the SWAp include improvements in understanding of how to plan a programme, more efficient budget allocations, linking programme outcomes to specific budgetary factors, and ease for donors to collaborate with other partners in health programming.

## 3.7 Facilitators and inhibitors of evidence-based policy

This assessment of health policy reforms in Bangladesh highlights various facilitators and inhibitors of evidence-based policy (EBP), specifically with regards to evidence that is used from other countries. These are identified below in relation to the various stages (conceptualisation, formation and contextualisation, internalisation and operationalisation, and evaluation):

**Facilitators:**

- At the conceptualisation stage facilitators of evidence in policy include:

  - the presence of in-country representatives from international agencies who understand the political, economic, and social circumstances to which reforms are introduced;
  - the identification of a need for policy alternatives by key decision makers in government; and
  - the alignment of goals between government and donor partners.

- At the formation and contextualisation stages facilitators include:
  - evidence from other countries is often highlighted and supported by donors, with the addition of in-country visits from policymakers to observe the implementation and formation of policies in other countries;
  - NGOs advocating for policies that they have seen to be effective in their programmes;
  - strong leaders and policy champions that own the formation and contextualisation processes; and
  - when guidelines from international agencies are provided.

- At the internalisation and operationalisation stages facilitators include:
  - the identification of specific needs of policies;
  - the role of donor organisations that provide technical and programme-specific evidence and assistance;
  - collaboration with NGOs in-country to provide expertise; and
  - consistency of policy goals with implementation. The consideration of political economy and institutional culture are also important for the effective development of policies.

- At the evaluation stage:
  - In the case of the health policy reforms in Bangladesh, evaluation has thus far included only the result of observations of health programmes. However, the evaluation stage may be facilitated by research that is conducted by organisations and programmes that are increasingly open to evaluating their own progress.

**Inhibitors:**

- Changing priorities of political parties and consequent annulment or discontinuation of the policies formulated by previous regimes (e.g. the closing of most community clinics after change of political power).
- Different levels of acceptance of policies between public agencies, especially when relative power or influence changes between departments (e.g. resistance to merging of family planning staff with health services at sub-district level, even though the policy had patrons at the highest levels).
- Effort to transplant policies from elsewhere without assessing a country's need and context.
- Lack of collaboration between government agencies in the operationalisation and evaluation of policies (e.g. Ministry of Finance may have limited interest in handing over power to the Ministry of Health for running the SWAp).
- Lack of follow-up and evaluation, as well as of studies that seek to understand the causes, mechanisms, and outcomes of health policy reforms.

# 4 Analysis/discussion

## 4.1 Patterns across the six stages of policy development

This case study illustrates that the development of the SWAp and community clinics in Bangladesh was primarily a result of the political influence of key in-country policymakers, the presence of donor partners, and technical assistance provided by domestic and international NGOs. The influence of evidence was minimal in comparison to in-country socio-political factors. Moreover, the utilisation of 'systematised' evidence was generally understood by interviewees to be unrealistic. However, evidence has functioned to inform agenda setting and technical assistance in conceptualisation and operationalisation, with evidence being produced but not utilised in evaluation. The Bangladesh SWAp and community clinics demonstrate that learning between countries happens in two circumstances: 1) where there is the involvement of international actors, and 2) gaps in policy and/or practice are identified.

The credibility of international actors in Bangladesh helped in the agenda setting at the conceptualisation stage, when learning between countries was facilitated. The use of examples from SWAps in Uganda and Tanzania demonstrated that expertise can be transferred and used through the networks of organisations, such as the World Bank, that operate in numerous countries. Most interviewees recalled that the SWAp was accepted as an approach to pooled funding, with the aim of reducing transactional costs and improving health system efficiency. Bangladeshi leaders within the Ministry of Health had a desire to address existing inefficiencies and since there was a possibility of more government-led coordination of health programmes and potential promotions as new line director positions became available. While in-country factors created a conducive environment for the policy to be internalised by the GOB, interviewees recalled that the idea for the SWAp came from international actors – namely the World Bank. Furthermore, this example illustrates the use of evidence in agenda setting, which occurred simultaneously internationally and within Bangladesh, with the push from donor partners to consider a SWAp and the identified need for health system reform by Bangladeshi health officials. Interestingly, interviewees did not view the technical community as having any influence over the conceptualisation of the SWAp. The reason for this was cited as broad agreement across the primary actors within Bangladesh, largely because of opportunities for promotion.

**There was a demand for technical assistance from government while operationalising policies.** Interviewees involved in the implementation of clinics and primary healthcare shared that they sought input from international organisations for technical assistance. Once the needs of community clinics were identified, they approached agencies such as the WHO and USAID with expectations and gaps, looking for support in the form of technical assistance. While broad strategies for policy development and implementation which are encouraged by international actors may not be useful to the health officials, technical assistance is useful. This demonstrates the need for contextualisation, as well as the use of evidence as a result of problem definition by in-country implementers. The technical assistance provided to community clinics by international organisations includes assistance in the development of the capacities of clinics, job descriptions, logistical and operational issues, and reporting on the Sustainable Development Goals. A respondent mentioned that international organisations are willing to help, but health officials should determine areas on which they want organisations to provide assistance and move towards a needs-based and evidence-based approach. Another interviewee identified the role of intermediary organisations such as UN organisations, which are not necessarily donors but 'intermediary recipients' of policy that provide technical support. Support from such organisations may include systems strengthening, development of standards, and overseeing the quality of implementation.

A number of interviewees mentioned that Bangladeshi officials visited Indonesia to understand their family planning programmes. However, the influence that trip had on the development of community clinics is unclear. Furthermore, there seems to be a lack of belief among the health officials in the idea of using  evidence There may be instances in which Bangladeshi officials' search for evidence from other countries has influenced health sector programmes; however, this was minimal for the community clinics. While health officials in Bangladesh may show an interest in learning directly from other health systems, this evidence is not always utilised. Learning between countries for policy operationalisation is more visible in the technical support provided by international organisations.

**It is understood that systematic evidence has not demonstrated the effectiveness of either the SWAp or community clinics.** However, even evidence that does exist, such as that produced by NGO evaluations of community clinics, is not being used. Furthermore, existing evidence is not 'systematic' in nature, in that evidence has not been systematically collected or examined. 'EBP' is often understood similarly to 'evidence-based medicine', the field from which EBP partially derived, in the sense that (often academic) proponents of EBP have an ideal picture of how policies should be developed. Specifically, proponents of EBP visualise a world in which policymakers are rational, are able to systematically rank alternatives, and prioritise evidence that is of high quality and has been critically appraised. Most practitioners and now many academics have come to understand an ideal-type of EBP to be unrealistic. This case study questions the role of EBP by suggesting that evidence is sought and acquired in various ways that may not be an 'ideal-type' process of policy development. As one workshop attendee stated: 'Policies are never evidence-based. Not in Bangladesh, not even in the UK.' However, the uptake of evidence that can be seen in Bangladesh through SWAp and community clinics is largely either advocated by international organisations from international sources, or sought by in-country officials who have identified a specific problem and seek solutions.

**The use of evidence is largely contingent upon the needs and motivations of in-country decision makers and practitioners.** The literature argues that policy transfer can be unsuccessful when political economy is not considered. However, the process of problem identification from within a country's health systems and operations before evidence is sought has only minimally been explored within the literature (McPake *et al*., 2017). While evidence has not been widely utilised in Bangladesh health systems reforms, this case study does illustrate opportunities for the use of evidence. For instance, evidence has been used in the provision of technical assistance and has played a role in the influence exercised by international agencies in agenda setting.

## 4.2 Institutions and mechanisms supporting evidence

Current institutions and mechanisms that support evidence include, primarily, donor partners that bring evidence from other countries in the conceptualisation of policies; NGOs that apply evidence from their programmes both within Bangladesh and from other countries; and relationships between health ministers from Bangladesh and other countries that facilitates discussion and the sharing of examples of effective implementation.

## 4.3 Potential facilitators of evidence

Overall, there is largely a lack of systematic uptake of evidence, even when partial evaluations, such as those conducted by Plan International and USAID of community clinics, exist. Improved collaboration between government agencies is needed to effectively plan and implement consistent goals for health policy development. Respondents mentioned the potential for a research unit, such as the one that previously existed in collaboration with universities in the United Kingdom, which

would assist policymakers to identify, analyse, and apply evidence. Finally, a needs-based approach to evidence should be promoted wherein donor partners and NGOs are increasingly responsive to specific operational needs of health programmes in Bangladesh.

## 4.4 Implications for future investments

The following points outline the implications of the case study findings for future investments in promoting learning between countries for health systems strengthening in LMICs.

**Approach**

- The assessment of in-country ('homegrown') needs for reforms based on the country's social, economic, and political environment is key to long-term success.
- The engagement of policymakers and politicians in the pairing of evidence with their motives and political agendas is needed; there should be an effort to inform policymakers about the benefits of using evidence to formulate policy.
- Relationships with international actors (donors, NGOs) that enjoy high credibility in the country can initiate the establishment of evidence through the presentation of learning experiences from other countries.
- Countries like Bangladesh, which allow space to donors for dialogues on policy reforms, are receptive to the presentation of evidence from other countries.

**Recommended Activities**

- Identifying champions of reforms at the leadership level in government, at an early stage.
- Providing technical assistance through donors at an early stage of reforms to assist countries in operationalising ideas.
- Hosting of officials and ministers of other countries to present on policies and improvements in their health systems.
- Facilitating exchange visits to other countries to observe and learn from other models of health policy, especially how different policies are implemented and evaluated.
- Holding forums where health programmes from both public and private sectors can present and learn from each other's approaches and findings.

**Recommended areas of collaboration**

- Meetings between stakeholders at several stages of implementation to ensure consistency of policy formation with how it is operationalised, and if it is not consistent, adapting implementation accordingly.
- Opportunities for NGOs to communicate challenges in their partnerships with public agencies and to explore solutions that are appropriate for both parties.
- Involvement of officials from Ministries of Finance to shorten decision-making processes concerning budgetary constraints.
- Given the GOB's increasing ability to meet higher SWAp contributions, continue to collaborate with the Ministry of Health to improve ownership and accountability of the GOB in relation to health programmes. Collaboration should aim to improve the financial capacity and sustainability of the GOB.

**Evaluation**

- Surveys and other forms of collection of information about satisfaction and service utilisation among policy beneficiaries should be carried out.
- Piloting and evaluation of new reforms and health programmes should be carried out.

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# Annex A List of interview respondents

| Position | Organisation |
|---|---|
| **Chief of Party, USAID-DFID NGO Health Service Delivery Project** | Pathfinder International |
| **Country Representative** | WHO |
| **Director Disease Control and Line Director CDC, Directorate General of Health Services (DGHS)** | CDC, Ministry of Health and Family Welfare |
| **DGHS** | Ministry of Health and Family Welfare |
| **Director, Health, Nutrition and Population (HNP) Programme** | BRAC |
| **DGHS** | Ministry of Health and Family Welfare |
| **Director, Primary Healthcare** | Ministry of Health and Family Welfare |
| **Additional Secretary and the Director General** | Health Economics Unit |
| **Senior Technical and Policy Adviser, Population, Health, Nutrition and Education** | USAID |
| **Director of the Centre for Child and Adolescent Health** | International Centre for Diarrhoeal Disease Research, Bangladesh (Icddr,b) |
| **Chief Technical and Planning and Coordination Adviser, Programme Management and Monitoring Unit** | Ministry of Health and Family Welfare |
| **Adviser (over phone)** | Asian Development Bank (ADB) |

# Annex B Workshop questionnaire

**Please answer the following question with regards to SWAps in healthcare.**

- Describe the processes which led to the reform taking place, including: 1) the specific actors who were involved, including who initiated, opposed, or influenced the reform; 2) major stakeholders engaged in the process; 3) how the reform was conceptualised and formulated; 4) the major issues and thought areas considered in the conceptualisation process; and 5) how it was implemented.

- How long did the process take to reach to fruition? What were the bottlenecks? Were there any alternatives considered?

- Was the policy's conceptualisation, formation, or implementation affected by the role of other countries or international networks? If so, how?

- What would you say were the 1) facilitators and 2) barriers to cross-country learning with respect to the development of this reform? What were the major challenges, barriers, and learning points of this reform?

- How did political economy play a role in the decision making process?

- If applicable, describe how your organisation or agency has impacted or been influenced by the reform? How has the reform impacted NGOs/CBOs and other development partners/communities? How has learning between countries influenced your role in health policy?

# Annex C Key findings from the workshop

## C.1 SWAp

| Phase | Factor | Mechanism |
|---|---|---|
| Conceptualisation and formation | Context | • The Ministry of Health had 128 projects, which meant 128 offices, staff, annual meetings, etc. It was overall an inefficient process. There was a sentiment within government that this was inefficient.<br>• The health sector had been part of the country since the British, but family planning existed since 1953. In 1964, there was an integration of family planning into government programmes. In In the consortium in Paris in 1996, donor agencies objected to the project approach and they were 'fed up' with reporting on so many programmes on a standalone basis.<br>• There was no evidence which was presented to support SWAps at the time, however if you consider the academic article to be evidence of some kind, that triggered a lot of discussion.<br>• Paris consortium was in 1996 and Health and Population Sector Strategy in 1996–97. |
| | Actors | • Dr Cassel published an academic article on SWAp that brought attention to the new approach. This was around the time of the Paris consortium, in which there was a consensus between government donors to follow the SWAp approach.<br>• Donor-driven, government cooperation, coordination in funds usage and prioritisation. |
| | Process | • From 1995 to 1998//10 years approximately//2 years.<br>• Concept started in 1996, and implementation in 1998.<br>• There was a continuous debate regarding how selective and continuous primary healthcare should be integrated.<br>• Nationally and internationally, a consensus was reached between government and donors to move to a SWAp approach.<br>• Some evidence came from practices around the country – for example, ESP was being practised in some rural areas, so evidence of these components had influenced certain components of SWAp.<br>• Series of international and national meetings and workshops.<br>• Through dialogue between government and donors, workshops with stakeholders, consultants from government, non-government, economists, public health experts, and clinicians.<br>• Donor-driven process from the World Bank and DFID.<br>• There was discussion of other countries' experiences in the workshop.<br>• Funding consortium was not in favour of a project approach and the government agreed on SWAp.<br>• No other country's experiences were shared. |
| Internalisation and contextualisation | Context | • If one calls SWAp a policy, there is no debate. However, if SWAp is a strategy, then it is more complicated, since usually a strategy follows a policy. In Bangladesh, however, you will find that the strategies are published before the policies. SWAp did not come from a national health policy, because Bangladesh did not have a national health policy at that time.<br>• Cost-saving in the national budget was a goal. |

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| | | • Donors had a political interest to divert funds to other regions. |
| | Actors | • Officials whose salaries would have been affected by policy reform were more likely to oppose change.<br>• The family planning cadre was against integration.<br>• Bottlenecks were grassroots acceptability, pool fund release, following a bureaucratic process, and resistance in fund release.<br>• Grassroots-level workers did not accept the reform initially.<br>• The family planning cadre was against the reform. |
| | Process | • The Paris consortium said, if you do not utilise a SWAp we will not provide funds for health programmes. So the secretary came back to Bangladesh, there were a series of forums, and the first document on Health and Population Sector Strategy was published. On that basis, by 1998, the first health population sector programme came. The planning commissioner championed this from 1996 to 1998 through different processes, then was approved within an hour. It was the first instance in which the projects started on schedule: 1 July 1998, otherwise the project could not have started within due time.<br>• In 1998 the ministry was 'struggling' with the new SWAp approach, but at the same time, none of the donors were ready to make it SWAp. Even if you consider today's system, it is not truly a SWAp, since it does not cover NGO or private services (only covers public services). It also does not even cover everything under the Ministry of Health, since the Ministry has projects outside of the SWAp. Furthermore, NGOs have parallel programmes outside of the SWAp.<br>• At the time, the World Bank was funding the HIV/AIDS Prevention Project, as well as the Bangladesh Integrated Nutrition Project. The Bank was not eager to put all these programmes under one umbrella (SWAp). Also at the time, USAID participated in the fund, but not the pool funding. USAID later participated in the third SWAp by creating its own pool, by giving money to the World Bank, which created a separate trust fund.<br>• ADB was also involved at the time and they wanted to be involved in urban health. Because of this, the Ministry of Health thought: go ahead with your own urban health projects.<br>• The local government and health secretaries signed a memorandum of understanding saying that the urban health programme would be coordinated outside of the government and the government would hand over its urban dispensaries. This was a deliberate decision.<br>• There was no evidence cited not to include urban health in the SWAp. |
| Operationalisation and evaluation | Context | • Several other countries started SWAps.<br>• Sub-contracting issues with government and NGO management. |
| | Actors | • NGOs were bound to work with the government.<br>• It impacted the prioritisation of areas of work of the NGOs and the availability of funds. |
| | Process | • The effect on NGOs was that there was no longer parallel funding for NGO and government projects, so NGOs had to fit in with the national agenda to receive funding for their health projects.<br>• Under the SWAp, urban health is mentioned differently and the approach remained (and still is) projectised. |

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| | | • Urban health was kept outside of the SWAp very deliberately, which is now being re-examined.<br>• Country benefited: reporting, monitoring, and supervision became easier.<br>• Addressing misuse and promoting efficiency, development, and essential services. |

## C.2 Community clinics

| Phase | Factor | Mechanism |
|---|---|---|
| **Conceptualisation and formation** | Context | • There was very strong political support.<br>• Two main factors: 1) health and family assistance were not meeting their quotas, and 2) increased access to services was needed.<br>• The 1994 conference urged countries to focus on more than just contraception and emphasised the need for larger reproductive health interventions, so it did not make sense to rely just on domiciliary services.<br>• Around the mid-1990s (and we can all agree that SWAps and community clinics came about as a result of the same phenomena), the Mexico population conference moved donors' opinions away from a contraception-centred approach to a broader reproductive health perspective.<br>• It is not clear to any of us why community clinics were suddenly decided upon. However, it is clear that the original house-to-house distribution of contraceptive services was very effective. However, it was a vertical programme, with separate ministries, and there was a sense that it was very expensive. Figures improved from the 1980s to the 1990s.<br>• What we realised is that domiciliary services could not cover the whole population and that workloads were increasing. The issue was how to bring services to the people and how to make services more demand-driven.<br>• There were two major driving forces: 1) the coverage at that time was only 38% of the population, and 2) people needed services closer to their homes.<br>• There was felt to be a need to increase community reach through complementary services provided by NGOs. |
| | Actors | • Involvement of government, donor partners, and NGOs.<br>• 'I don't think this comes from the Bangladeshi Government at all.' This whole thing was driven by donors.<br>• 'I think it was the World Bank that came up with the approach.'<br>• The World Bank gave a big push since community clinics went hand-in-hand with the merging of the ministries.<br>• There are no data on why clinics were favoured by the government, but my suspicion is that they were favoured by donors. Did the donors influence government? Certainly, and during this time, community clinics came as part of government.<br>• The concept of community clinics was in line with NGOs and community-based organisations.<br>• Plan International and other NGOs worked closely on this reform. |
| | Process | • Donor, government, and NGO discussions with stakeholders.<br>• No alternatives were considered.<br>• No political agreement.<br>• Incorporation with annual health policy. |

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| **Internalisation and contextualisation** | Context | • 'Policies are never evidence-based. Not in Bangladesh, and not even in the UK.'<br>• Goals of essential services provision, sustainability, and efficiency.<br>• Political commitment.<br>• Political economy played a role: women's empowerment issues, SWAp, and integrated service delivery.<br>• Goal: to achieve MDGs and reach the target of becoming a middle-income country.<br>• Change in political party. |
| | Actors | • It was also a donor-driven approach: USAID tested clinics in a small number of areas and brought it to government who expanded it. We thought, 'Let's go for it! – it's a low-cost strategy to build clinics where satellite clinics exist to provide both Expanded Program on Immunization and reproductive health services. This let us establish 6,000–7,000 clinics, and over 14,000 clinics were then established.<br>• Bangladesh wanted to reduce cost. While they were searching for solutions, examples from USAID and Red Cross clinics came up. Then they thought they could integrate the ministries and have community-based clinics to reduce costs. |
| | Process | • The community clinics were a major part of the political election of the Awami League in 1996. It is not clear how it became part of their platform; however, they certainly made a big deal of it.<br>• We piloted clinics at the community levels for cost minimisation. If evidence is not published in a journal, the outside world does not know about it. Within the country, however, you could see 'evidence' of the clinics working.<br>• There was a series of working papers on how community clinics would work from within the government.<br>• Political commitment over bottleneck and procurement issues. |
| **Operationalisation and evaluation** | Context | • The 2005 Paris summit resulted in NGOs not being able to apply for grants unless they worked with the government, which impacted small-scale, primary care services. We (NGOs) were concerned about our sustainability if we were not able to get funding for the government. Community clinics were a 'win-win' for us to be able to continue our services in partnership with the government. After the 2005 Paris summit, we were looking at what was happening nationally to see how we could fit in with policy.<br>• Facilitators: women's involvement, equity issues, and microfinance.<br>• Government was a facilitator. |
| | Actors | • Plan International took the lead in promoting a community-based approach at the time.<br>• The community clinics were politically pushed, but actually, the people behind it were the technical people. The reason why they were shut down, however, was purely political.<br>• Good example of partnership and use of resources between the public and private sector. |
| | Process | • 20 years approximately, with a gap in the middle of six years.<br>• One-stop facility close to people's homes.<br>• Community clinics were a phased approach (but no randomised control trial); a large-scale pilot.<br>• Clinics were stopped with the change in government. However, they were still continued through NGOs. |

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| | | • Clinics were shut down unnecessarily. It was for the purposes of a campaign that services were taken away from poor people. After 1998, for some time and for political reasons, it was stopped. When it started again, it started as each clinic serving 6,000 people, although now it is more than that.<br>• NGOs kept providing services at the community level when the government was not.<br>• The beauty of the community clinic concept is that it was to be looked after by the community. Eight people from the community would form a committee to support the clinic.<br>• Formalising satellite clinics.<br>• Making community support groups. |

# Annex D List of workshop attendees

| Position | Organisation |
|---|---|
| **Programme Head, Health, Nutrition and Population Programme (HNPP)** | BRAC |
| **Programme Manager** | Population Services and Training Centre |
| **Programme Manager/Team Leader for Inclusive Business-Based Sexual and Reproductive Health Rights (SRHR) Initiatives in Ready Made Garment (RMG) Sector** | Foundation of Netherlands Volunteers (SNV) |
| **Programme Director** | Association for Community Development Programme |
| **Executive Director** | Radda Maternal and Child Health-Family Planning Centre |
| **Organisational Development Director** | LAMB Integrated Rural Health and Development |
| **Team Member, USAID-DFID NGO Health Service Delivery Project** | Pathfinder International |
| **Technical Officer** | UNFPA |
| **Adviser** | Institute of Epidemiology, Disease Control and Research |
| **Vice Chancellor and Dean** | International University Bangladesh |
| **Professor and Head** | State University |
| **Head of Midwifery Education** | BRAC University |
| **Professor** | National Institute of Post-Graduation Health and Social Science |
| **Head, Initiative for Non-Communicable Diseases** | icddr,b |
| **Project Director, Universal Health Coverage, Health System and Population Studies Division** | icddr,b |
| **Associate Scientist, Health Systems and Population Studies Division** | icddr,b |
| **Country Manager** | Joint United Nations Program on HIV/AIDS (UNAIDS) |
| **Senior Adviser, Achieving Sustainability Towards Healthcare Access (ASHTA), Improving Rural Healthcare Service Through Community Paramedic Programme (IRHSCPP)** | Swiss Foundation for Technical Cooperation |
| **Chief Adviser, Strengthening Health Systems Through Organising Communities (SHASTO) Project** | Japan International Corporation Agency |
| **Consultant** | Former Government Staff/DFID |
| **Former Director** | Institute of Epidemiology, Disease Control and Research |
| **Former Director of Maternal and Child Health; ex-BRAC staff; Current Adjunct Faculty** | American International University Bangladesh (AIUB) |